



Birth of Health Assembly

Crystallization of Learning towards Wellbeing



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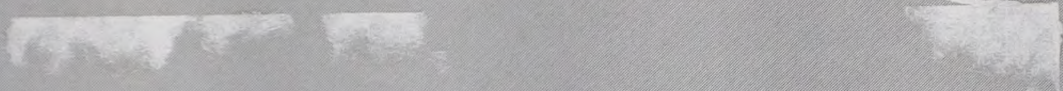
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National Health Commission Office

For
CHC
from the National Health
Assembly Feb 2012
B 89

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Crystallization of Learning towards Wellbeing

Published by:

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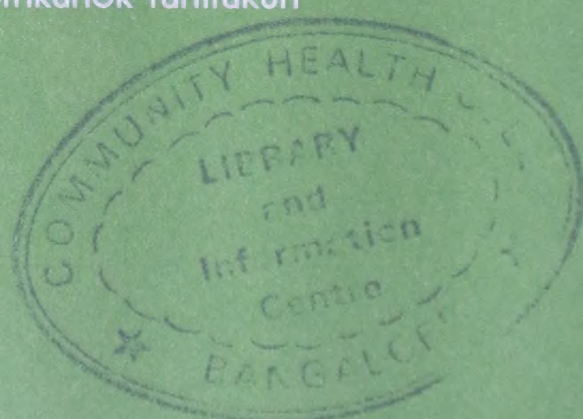
First Printing:

October 2008

ISBN 978-974-389-571-5

Printing Office:

Sangsue Co., Ltd.



PH-100
14074 P08

PREFACE

This volume of "Birth of Health Assembly: Crystallization of Learning towards Wellbeing" is a collection of thoughts and experiences about promotion of participatory democracy through the public sphere and civil society movement, advocating "health" as the central issue.

The intention behind this book is to demonstrate the power and dynamics of the public process based on the participation of all social sectors via the "Triangle that Moves the Mountain" strategy. It also shows how this strategy will eventually lead to the development of the public policy on a participatory basis, how it all starts with the smallest social units indispensable to the movement toward wellbeing.

The National Health Commission Office (NHCO) would like to thank Ms. Saisiri Danwattana for synthesizing and editing the work to ensure that the message will properly reach the society how the health assembly process has developed over the years and how participating sectors have made their presence felt. In this way the body of knowledge that is formed will be disseminated to the general public and grow even further. Thanks must go to all the health partner networks in the country whose cooperation and advocacy has helped move forward the health assembly process time and again. The NHCO is also most grateful to the resource persons, academics and many others for their analytical and editing work that help to make this work more complete as well as for their contributions over the years.

National Health Commission Office (NHCO)
October 2008

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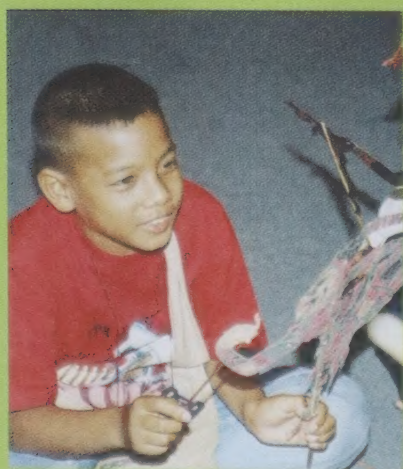
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Introduction

In the Stream of
Health System Reform



INTRODUCTION

In the Stream of Health System Reform

The health system reform movement in Thailand has been going on for more than two decades, because a group of academics, public health administrators and civil societies have been concerned about the direction public health was taking. The tendency has been to rely more and more on external technology in treating diseases and illnesses at the expense of personal healthcare and self-reliance. Health problems are no longer a matter of communicable diseases but something caused by unhealthy social environments and inappropriate behaviours. As a result, all the efforts to expand and increase services cannot meet the rising needs of the population. The problem is compounded by the market system which has entered the fray to meet and at the same time create more public consumption needs. Consequently, health costs have risen at a higher rate than the national economic growth while people's health still suffers. The rich and the poor do not get access to the same healthcare services. There are

also problems of the quality and effectiveness of the system. The national health policy still adopts a reactive approach to development with little participation from all parties concerned.

The principles on which the new health care reform is based are to primarily prevent diseases, promote health, make health work more holistic, and encourage the public, community and society to play a more active role in health promotion and capacity building, taking individual and collective action. This will help shape the health policy and administration at the community, local and national levels.

Guided by such concepts, numerous movements, big and small, have come into being as the occasion might warrant. The wave of one movement reinforces that of another, leading to a bigger wave. The situation can be summarized as follows:


- **Independent Mechanisms: Window of Wisdom and Participation**

The initial advocacy for the health system reform was driven by the search for knowledge and its dissemination at various forums and seminars. An event that triggered significant change took place in 1986 when the National Epidemiology Board of Thailand (NEBT), chaired by Prof. Dr. Prawase Wasi, was created with the support from the Rockefeller Foundation. The Board has played an important role in promoting health researches in issues that are related to other sectors.

In 1988 the National Epidemiology Board in cooperation with several other agencies convened a “national public health assembly” in Bangkok. This was the first time that the top administrators from nearly every ministry in the country met to exchange views on health development. The meeting witnessed a series of discussions and technical presentations on new health issues. One of its recommendations was to create a “public health council” to interact between different medical branches and between different ministries. These branches and ministries could then be brought together to work on health development issues. It could be seen, therefore, that the main focus was still on the cooperation between government organizations.

That was the first and only public health assembly that was convened. The public health council did not come to fruition, because the situation and state of knowledge at that time were not yet ripe for such a council. Nevertheless, the attempts to reform the health system structure and mechanisms continued. The National Epidemiology Board managed to have several independent mechanisms created. In 1991 the National Public Health Foundation was set up, with Dr. Sanguan Nittayarumphong, as its first secretary-general. In 1992, the Ministry of Public Health created the Health Systems Research Institute (HSRI) as a funding agency to promote health researches by academics in the country with Dr. Somsak Chunharas as its first director. Thanks to the academic freedom enjoyed by the National Public Health Foundation and HSRI, a lot more researches have been

"More social movements and knowledge dissemination have also made it possible to advocate health policy, development and reform on a continual basis."



conducted and a greater network of academics has been made possible. More social movements and knowledge dissemination have also made it possible to advocate health policy, development and reform on a continual basis.

In addition, the Health Care Reform Project was initiated in 1996 as a result of cooperation between the Ministry of Public Health led by Dr. Sanguan Nittayarumphong and the European Union (EU). The project played an important part in the development of universal health coverage and generated considerable academic inputs on public health care management. As a result, more knowledge was disseminated with many new models that eventually led to public health care reforms and universal health coverage.

- **Health Civil Society: Formation of Undercurrent Forces**

The health movement by civil society has been in existence for more than twenty years alongside the political movement. Thai civil society became stronger; a number of students and intellectuals took up rural development challenges. As the government policy during that period focused on accelerating rural development, several civil societies decided to embrace the task of developing local communities in various aspects including economy, education, public health or environment. Thus, they played an important part in re-directing social movement. During the last 20 years or so there have been so many interesting health civil societies, e.g. Rural Doctor Foundation, Local Doctor Foundation, Public Health Foundation for Development, Thai Association for

Voluntary Sterilization, Consumer Protection Foundation, and Thai Holistic Health Foundation.

In addition, the primary health care policy of 1977 encouraged the growth of health volunteer workers under the auspices of the people sector. It was difficult, though, to fully gauge its success in solving community health problems, as it tended to adopt a vertical bureaucratic approach. However, the experience in public health management was multiplied. For instance, attempts were made to set up drug funds through mobilization of public support for community self-care.

The health civil society sector continued to grow and expand its network after the HIV/AIDS pandemic in 1992. HIV/AIDS became an issue that drew other civil societies to join their health counterparts. There were about 170 such non-governmental organizations.

On the whole, the health civil societies and groups are not large in size but numerous and diverse in nature, ranging from environment, law to women's rights. They work as a network, keeping each other closely informed. This type of cooperation is called health partnership. Together with local sages and mass media, they help to ensure that health and other issues are properly integrated. At the beginning, their work was focused on social welfare or charity work. Now it covers protection of rights, education, knowledge building, development of alternative healthcares, and proposal of social recommendations. It is moving toward participatory public policy formulation for health.

The involvement of the civil society in health was formally introduced for the first time at the conference held by the HSRI in 1996. Since then it has triggered more and more interests in health advocacy.

• **Health Promotion: Changing Direction of Stream**

After the WHO launched its Health for All strategy in 1978, Thailand announced its primary health care policy which has served as the basis for health promotion in the country ever since. The WHO has convened a series of International Conferences on Health Promotion on a regular basis. The first was held during 17-21 November 1986, giving rise to the Ottawa Charter for Health Promotion. The Charter was the source of inspiration for health promotion, identifying five action areas:

1. Building healthy public policy
2. Creating supportive environments
3. Strengthening community action
4. Developing personal skills
5. Reorienting health care services from curative services toward promotion of health.


Although the governments around the globe at that time were well aware of the importance of health promotion, the health budget was allocated to treatment of illnesses in the most part. In Thailand, there were movements, such as No Smoking Campaign projects and Folk Doctor Foundation in 1986, establishment of the National Committee for Control of Tobacco Use (NCCTU) in 1989, establishment of the Office

for Tobacco Consumption Control (OTCC) in 1990, and establishment of Health Systems Research Institute (HSRI) in 1992. All this significantly spurred on numerous activities designed to promote health, including academic work, social movements and advocacy for policy to use sin tax for health promotion campaigns.

As a result of concerted action for more than eight years, Thai society finally saw the Thai Health Promotion Foundation (ThaiHealth) created by the Health Promotion Foundation Act in 2001. Its objectives included health advocacy, support and promotion while its revenue derived from 2 percent of the excise taxes on tobacco and alcohol. The money was used to fund various agencies, organizations, groups, networks and communities for their work in translating “health promotion” into concrete activities. Indeed, the health promotion trend would become even more prominent with time, moving forward incessantly like a fast-flowing stream

• **Health Security: Waves of Change**

A health security system was one of the essential prerequisites in the health care reform. The health system, hitherto based on local wisdom and inter-dependence, had inclined toward the service system that favored clinics and hospitals as well as medical costs. A health security system would guarantee medical treatment and care for the people when they most needed it. The year 1963 saw medical welfare given to civil servants. In 1990 the first social security act came into being. For the general public, the Thai government



introduced the health insurance scheme first to the needy and poor, giving rise to the medical welfare card regime in 1995. It later became the public welfare scheme for medical treatment, providing health security as a “right” to which all people, especially the poor, were entitled. However, the health security for the poor only was beset with many service quality problems, while some sectors of the poor never enjoyed that right. Thus, it was advocated that Thailand should introduce universal health coverage. This was something that all nations in the world want to achieve though very few have succeeded.

Decades of efforts in education, network formation by the people sector, and policy advocacy finally led to some significant change. This was in part due to the Health Care Reform Project (1996-2000). Not only did the project provide a good opportunity for learning about how to organize public health services and health insurance scheme, but it also came up with possible health service and insurance models. The people sector also participated and set up a network for universal health coverage. In 2000 it submitted its version of National Health Security Act. At the same time the Thai Rak Thai Party came up with a thirty-baht universal health care coverage scheme in its general election platform in 2001. After the party won the election, the Thai Rak Thai government set out to implement the “thirty-baht scheme for universal health care”, and the National Health Security Act was passed in 2002. This is the first milestone of the attempt to achieve universal health coverage.

The present universal health coverage system covers more than 46 million people, representing 35% of the total population. The system led to financial and fiscal reforms as well as restructuring public health service management mechanisms. These were significant waves of change impacting the direction the Thai health system was taking. Over the past years these repercussions have become issues for public debate, ranging from health basic philosophy to guidelines for implementation.

Even now the Thai health insurance scheme is still in the mid of the vast stream of change where more challenges lie ahead. To reach this still distant goal in a sustainable manner, the system must be characterized by equity, quality, efficiency and accountability.

- **Current of National Health System Reform: Slow but Subtle Flow**

Amid all the movements and changes that were taking place, there was a widespread belief that the health system should cover all dimensions and that the Thai health system lacked an “umbrella” under which all health efforts and supervision should come.


The years 1999 and 2000 saw the movement for a national health system reform formally recognized when the Prime Minister’s Office issued a Regulation on National Health System Reform which came into effect on 31 July 2000 with the following rationale:

“Since the present national health system is unable to provide the people with an adequate health service and quality of life as prescribed in the Constitution of the Kingdom of Thailand, it is expedient to undertake a national health system reform and put in place a national health act to achieve that end.”

“The national health system” is defined as “a set of all the holistically related systems able to affect the health of the entire nation, including all health-related factors whether they are personal, economic, social, physical or biological as well as health service system.” At the same time, *“the national health system reform” is defined as “any process that leads to a change in the management of the national health system designed to provide good physical, mental, social and spiritual health for all as well as to enable the public to get access to health services when necessary on a fair, effective and quality basis.”*

The framework of the national health system reform under the Regulation of the Prime Minister’s Office was intended to reorient health care from curative services to a more proactive approach to good health. A system would be set up to promote health and prevent diseases. People would not become ill unnecessarily. The assumption was that good health cost less than cure. When people’s health was not in jeopardy, there would be enough resources to put in place quality services to which every Thai citizen could get access without being hampered by economic barriers. Attempts must also be made to reform the thinking and

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attitude of the Thai population about health. All the existing sub-systems must be channeled into a desirable health care system that could provide good health for all. All this was based on the draft National Health Act as the national health statute and would require participation of all sectors concerned. The drafting of the National Health Act was, therefore, a means to an end as well as a target to reach. The law was not intended to simply enforce the reform as had been the case with many nations that failed in their reform efforts.

From the outset the national health system reform was not geared toward becoming a bureaucratic mechanism. The intended mechanism must operate in connection with three important sectors at the same time, i.e. people, academic and political. A National Health System Reform Committee (NHSRC) was set up, chaired by the Prime Minister, and consisting of members from the ministries concerned and qualified persons from various fields and sectors. As a result, the National Health System Reform Office (HSRO) was created as an independent agency under the supervision of Ministry of Public Health, and its function was to serve as focal point and as secretariat of NHSRC. The HSRO director was Dr. Amphon Jindawatthana, former director of Praboromarajchanok Institute of Health Workforce Development, Ministry of Public Health. Such a mechanism as HSRO was expected to manage the advocacy of the health system reform in a most extensive manner, especially when working with the civic sector without losing sight of the

political sector and Ministry of Public Health, the backbone of the health system.

Under the framework supervised by the NHSRC and HSRO, a new desirable structure was initiated, consisting of the following eight sub-systems:

1. Health promotion system
2. Disease and health-hazard control system
3. Health care finance system
4. Public health service and quality control system
5. Consumer protection and empowerment system
6. Local health wisdom system
7. Knowledge and information system
8. Health personnel development system.

Reform Strategies and Goals




(Source: "Health System Reform: What Reform? Why? How?", HSRO, 2000)

Under the NHSRC there were 4 sub-committees:

1. Technical Subcommittee, responsible for knowledge generation and management to support the health system reform.

2. Social Cooperation Subcommittee, responsible for promoting social networks and strengthening the civil sector in the national health system reform efforts.

"The reform moved forward
in greater intensity
because of the existence
of *health assembly*."



3. Public Communication Subcommittee, responsible for promoting awareness, understanding and supporting the reform process as extensively as possible through adequate communication.

4. National Health Act Drafting Subcommittee, responsible for developing health system concepts and materials, drafting the National Health Act based on all the good things that came out of public forums and the civic process, making recommendations and monitoring their implementation.

When the three years as prescribed by the Regulation of the Prime Minister's Office had elapsed, it was discovered that more social cooperation was in evidence and that attitudes toward the new dimension of health were more positive, reinforcing all the actions that had gone before and came afterwards. Unfortunately, the National Health Act was not passed in the expected timeframe. The NHSRC and HSRO had their terms extended to July 2005 and again until the completion of their missions. Thus, the reform moved forward in greater intensity because of the existence of health assembly. The assembly was both a process and a forum capable of mobilizing, initiating, experimenting and developing ideas from the local level to the national or even international level.

The reform events during 2000-2005 could be summarized as follows:

* **3 May 2000:** The Health Systems Research Institute (HSRI) organized a national seminar on "Health System that Thai People Want", the first ever forum to trigger off the health care reform, followed by six other regional forums.

* **31 July 2000:** The Regulation of the Prime Minister's Office on National Health Care Reform was issued.

* **9 August 2000:** The National Health System Reform Committee (NHSRC) convened its first meeting, approving the four strategic plans: 1. plan for knowledge generation, 2. plan for social cooperation, 3. plan for public communication, and 4. plan for managing and drafting the National Health Act.

* **November 2000-January 2001:** A concept paper or blueprint for national health care was drafted as a basis for brain-storming forums in the drafting of the National Health Act.

* **February 2001:** More than 500 brainstorming sessions were held by health partners, groups, and organizations, including Network of People with Disabilities, Women Action Network, Traditional Thai Health Network, Network of the Poor, Network of I-san Local Sages, Network of Informal Workers, Medical Council, Nursing Council, Rural Doctor Society, Ministry of Public Health, and Health Doctor Network.

* **September 2001:** The National Health System Reform Office (HSRO) in cooperation with other 125 organizations organized a "Health System Reform Fair" to demonstrate

health assembly models and to receive feedback and recommendations on the subject.

* **After the first demonstration forum**, all the recommendations were synthesized and reviewed, forming the corpus for the document “Essence of National Health Act”. About 550 more district assemblies were held, representing about 50% of the total number of districts (Amphoe) in the country.

* **April 2002**: The first draft of the National Health Act was completed. Seventy-five provincial health assemblies (except Bangkok) were held for public hearing on the Act and for public support. The draft then was revised several more times before being submitted to the National Health Assembly in 2002.

* **7-8 August 2002**: The first full National Health Assembly was organized, putting the revised Act to the public hearing. Prime Minister Thaksin Shinawatra was present to receive recommendations and promised to move to action as the head of the government.

* **After the 2002 National Health Assembly**, the National Health Act Drafting Subcommittee synthesized the recommendations. The draft act was submitted to the cabinet on 24 September 2002, but it would need to go to the scrutiny of Screening Committee No. 3 before being tabled for the cabinet’s consideration

* **November 2002**: Running and bicycle races were organized under the “Follow His Majesty’s Footstep” Campaign. Participants from the four regions took five different routes to Sanam Luang; 4.7 million signatures were collected in

support of the Act and submitted to the House Speaker (Mr. Uthai Pimjaichon) to carry the motion forward.

* **December 2002-January 2003:** Health assemblies for children and young people were organized in cooperation with other child partner organizations from all regions, providing an opportunity for them to learn about wellbeing. A significant activity, named "Miracles that We Could Produce", allowed young people to exchange views on wellbeing and propose recommendations to the government (represented here by Deputy Prime Minister Mr. Chaturon Chaisang). The event was televised live nationwide since it was the 2003 National Children's Day.

* **21 January 2003:** At the cabinet meeting, the Prime Minister instructed the draft National Health Act, already approved in principle by Screening Committee No. 3, to be submitted further to Screening Committee No. 6 (for legal consideration).

* **May 2003:** The cabinet approved the extension of the NHSRC and HSRO for two more years as they had to see to the passage of the National Health Act.

* **June 2003:** The 2003 health assembly process began by organizing local (regional) assemblies and assemblies on specific issues. The assemblies considered issues that affected the communities and related them to the provisions in the draft National Health Act, especially the health promotion clauses. Policy and strategy recommendations were made at the local level, reflecting what it would be like if the Act was finally implemented.

* **8-9 August 2003:** A national health assembly was organized, incorporating all the issues and recommendations made by the local assemblies and assemblies on specific issues. Recommendations were proposed to the government and agencies concerned. The national assembly also advocated for the civil society sector to put the recommendations in practice.

* **28 August 2003:** The NHSRC set up a working group to study and synthesize the health assembly recommendations with a view to having them implemented or incorporated into the public policy.

* **Early 2004:** The people sector formed a network to campaign for the people's version of the National Health Act. The social movement conducted an activity called "Good Citizen Operation" and submitted a petition endorsed with 123,416 signatures to the House Speaker.

* **May 2004:** Area-based and issue-based health assemblies were organized to prepare policy and strategy recommendations to be submitted to the 2004 National Health Assembly. There were 173 area-based health assemblies attended by 32,000 participants covering 346 topics, while there were 11 issue-based health assemblies attended by 480 participants covering 31 topics.

* **8-9 September 2004:** The 2004 National Health Assembly was organized, attended by 3,500 participants. The main theme was "Healthy Food and Agriculture – Chemical Hazards", together with ten other issues. Health-promoting innovation practices were introduced in the "Learning Fair for

Wellbeing" covering 73 topics.

- * **10 August 2004:** The cabinet approved in principle the "Triangle that Moves the Mountain" version of the draft National Health Act which was submitted further to the Council of State for consideration.

- * **27 April 2005:** The people sector's version of the draft National Health Act was re-introduced as new item on the agenda for the House of Representatives' consideration.

- * **May 2005:** A special committee of the Council of State amended the "Triangle that Moves the Mountain" version of the draft National Health Act. The amended version was to be submitted to Parliament.

- * **7-9 July 2005:** The 2005 National Health Assembly was organized, in accordance with the spirit enshrined in the draft National Health Act, under the theme "For Wellbeing". Recommendations on policies and strategies for wellbeing of 12 issues were proposed.

- **National Health Act and Health Assembly**

In the explanatory note that accompanied the Draft National health Act, all measures, as well as health policy and strategy would be made possible through a set of health policy mechanisms, i.e. National Health Commission (NHC), the National Health Commission Office (NHCO), and “Health Assembly”.

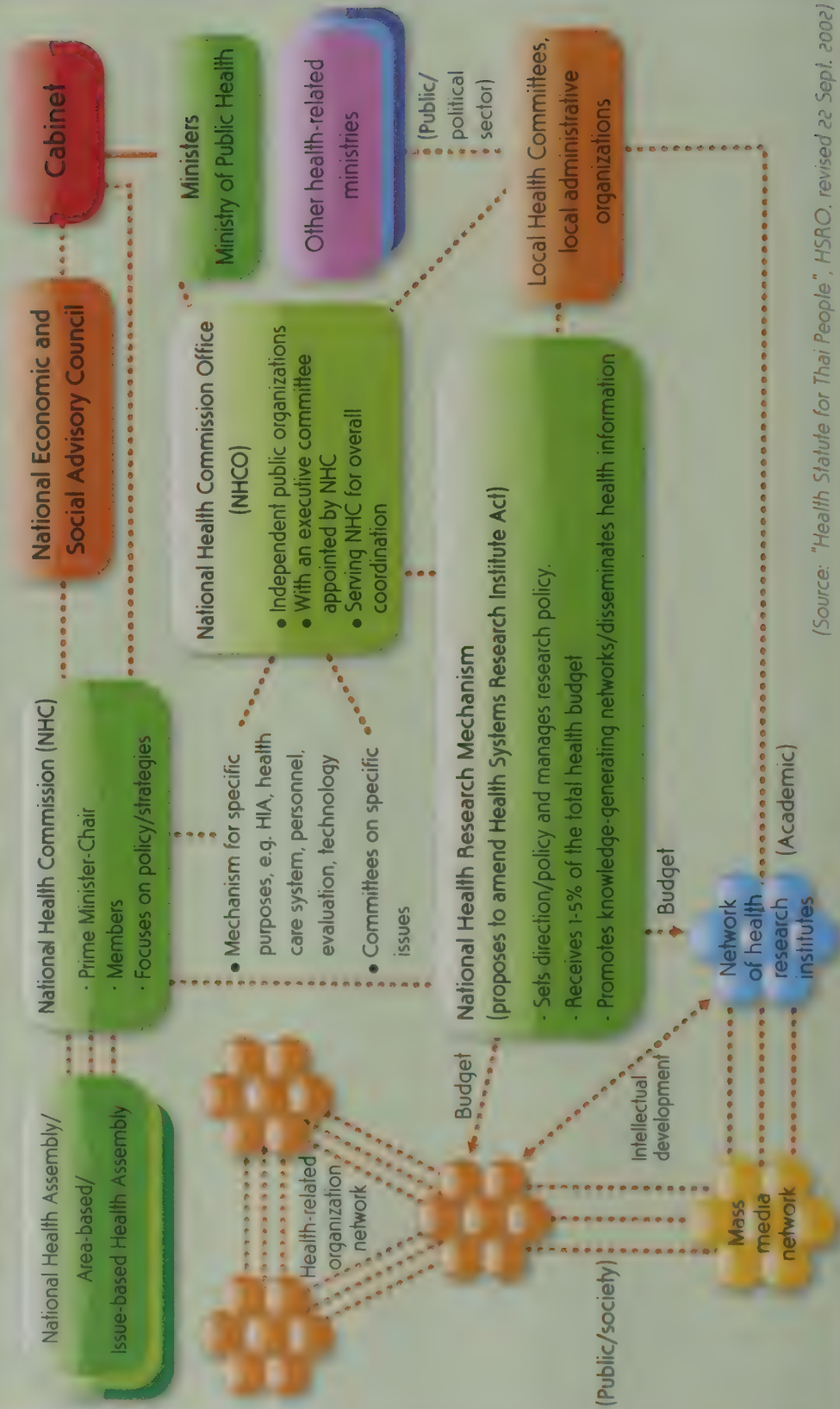
The National Health Commission would be composed of three sectors: the political and government sector, academic and professional sector, and people sector. The commission was to be chaired by the Prime Minister. It would be responsible for setting, recommending and advocating health policies and strategies as well as making sure that they were implemented. The NHCO would serve as its secretariat, working through local and national health assemblies.

The following was a definition of a health assembly.
“A health assembly is a meeting process in which all parties exchange their knowledge and cordially learn from each other with a systematic organization and public participation leading to wellbeing.”

The goal of having the National Health Act as a health statute was to provide a direction for all the waves that came together in the health system reform current to be able to reinforce one another. The drafting of the act was made not just for the sake of drafting a law, but a social movement with common objectives. This kind of reform would take time and patience, and results would be gradual.

“The stream of change flowed slowly, with slow results. It was a slow but subtle flow.”

Proposed National Health Policy Mechanisms Working with Other Mechanisms



1.

Source of Health Assembly:
Concepts and Goals



CHAPTER 1

Source of Health Assembly: Concepts and Goals

The health assembly process occurred within the context of the national health care reform driven by the NHSRC, HSRO and other partners nationwide. It served as an instrument connecting all the movements including drafting of the law, advocacy, campaigns bringing about the necessary paradigm shift, public communication, empowerment of the people sector in the participatory process, and setting of public policy. In the beginning the health assembly was considered an “action research” process in which practice, learning and findings would go hand in hand until a suitable format was found and all the participating partners understood and knew how to act in concert. The work touched on many dimensions at the same time. No one dimension could be left behind; no one sector could achieve the result single-handedly.

• Origin and Meaning of “Assembly”

The Thai word for “assembly” is “samatcha”. In the revised Thai dictionary of 1995 an “assembly” is defined as a meeting or a general meeting. The Thai morpheme “smach” or “smatcha” means a general meeting, meeting face to face, making friends, fun, entertainment, play and performance attended by a big audience.

The English word “assembly” derives from ecclesia, a Greek word meaning communication, information sharing, convincing, or persuasion by a leader, usually a commoner, to instigate a political movement in order to resolve an issue that demands attention from the state or governor. Another Thai translation of the word is “sapha”, as in Ratthasapha Thai which means Thai National Assembly.

Ecclesia also means meeting or coming together to worship gods or for other religious purposes, including Christian and Jewish faiths. Such a meeting is sometimes called “congregation”, a meeting of like minds in an organized setting. The participants choose to attend certain activities because they are happy with what they hear, with something that they are attuned to. Such congregation brings personal esteem to them.

In the modern time the word “assembly” is mostly used in two ways:

1. It is a process of building something by putting all its parts together, e.g. an assembly plant where all the parts must fit in perfectly together to make a product.

2. In the context of social interaction, it means the gathering of people for common purposes. An assembly can refer to a group of people who meet together or a place of meeting. One of its synonyms is “forum”. It can be an open discussion. It also functions as a verb meaning to bring a group of people together in one place, as in a social act of assembling.

An assembly in the sense of a meeting together of people can be specific or general. In a specific sense, the assembly refers to a meeting of people to draft law, lay down social rules, or set a policy of some sort. Such examples are the General Assembly, Legislative Assembly, National Assembly, and Tribunal or Judicial Assembly. The usage is usually limited to government or international bodies. It is not used with private organizations. For instance, the International Standard Organization (ISO) is governed by the ISO Statutes through such mechanisms as the General Assembly, the Technical Management Board, and the Council. The same applies to other international bodies like the United Nations, Security Council, and WHO. Similarly, WHO is governed by its World Health Assembly.

Thus, the word “assembly” tends to be used in the official or public context. In its narrow sense, it is charged with policy and making-decision power.

On the other hand, when the word is used to refer to social movement by the people sector, it carries a deeper level of significance, referring to a meeting together to demand certain rights or to air social sentiments. Such a meeting can

"The health assembly under the national health system reform relies on *mechanisms for participatory health policy* that reflect the dynamic changes of social, economic and cultural conditions of Thai society."

be called a convocation, congregation, or convention. When the assembly is held, it usually comes up with some kind of agreement or recommendations, such as a declaration or convention, as was the case with the first People's Health Assembly (2000) held in Bangladesh or the World Social Forum (2001) in Brazil.

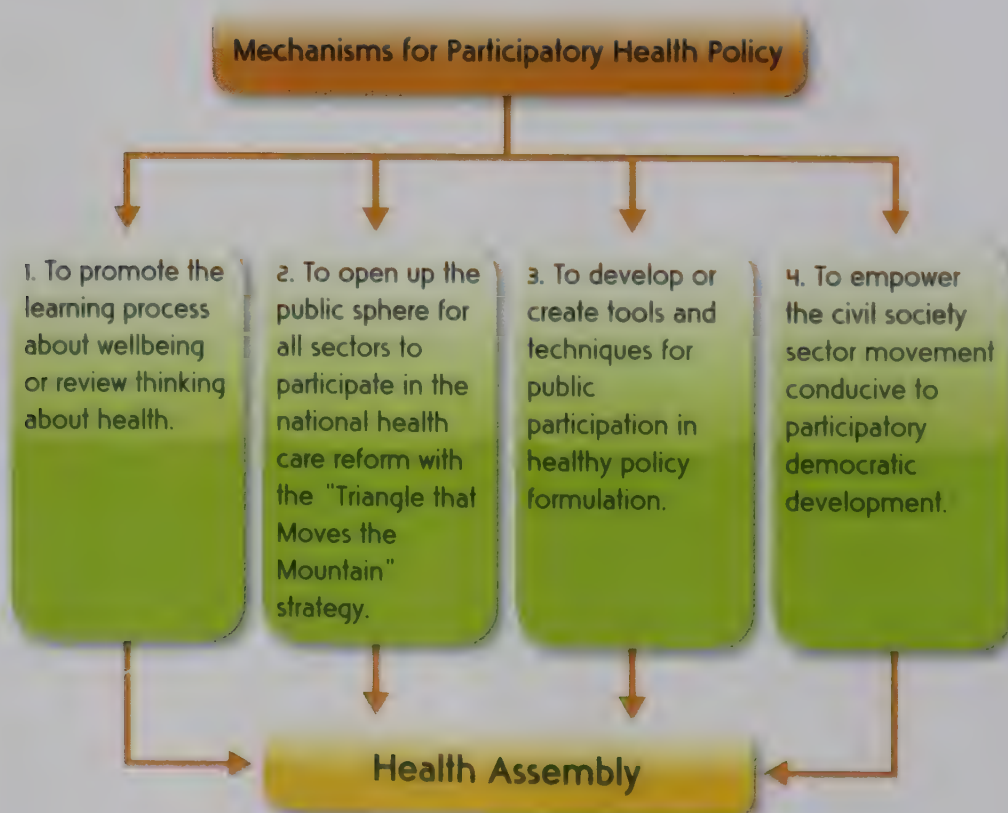
In Thailand, the assembly has been used for several decades to refer to a group of activists or people's movement. Thai society is familiar with "the Assembly of the Poor", "the Assembly of Small Farmers", and "the Dam Assembly". To the public, when the word "assembly" is mentioned, it is charged with a negative connotation, perhaps because the action that it tends to take includes rallies, demonstrations, demands, or petitions to the State to redress grievances. When such demands are not shared by the general public, they can be perceived as coming from some interest groups or other. Worse, the assembly could be viewed as an unnecessary nuisance caused by an interest group.

Whether or not the "assembly" is an appropriate choice of word in the health care reform movement has long been a subject of debate on account of its negative association. Nevertheless, it has been used since the beginning to reflect a wise and friendly process (in other words, academic and constructive). Interestingly, such use of the word "assembly" has caught on. Now we see "the Science Assembly", "the Sustainable Agriculture Assembly, and, more recently, "the Assembly of the Democrats". The last name refers to the reform movement of the Democrat Party after the last general election.

• Mechanisms for Participatory Health Policy – Goal of Health Assembly

The health assembly under the national health system reform relies on “mechanisms for participatory health policy” that reflect the dynamic changes of social, economic and cultural conditions of Thai society. The health assemblies that were carried out on an experimental basis and that showed a diversity of activities were based on four main objectives:

1. To promote the learning process about wellbeing or review thinking about health.
2. To open up the public sphere for all sectors to participate in the national health care reform with the “Triangle that Moves the Mountain” strategy.
3. To develop or create tools and techniques for public participation in healthy policy formulation.
4. To empower the civil society sector movement conducive to participatory democratic development.



I. Promotion of Learning Process for Wellbeing

A “**health paradigm**” is a way of thinking about health that plays a significant role in the organization, work system, policy and practice of the national health care reform. The assembly health approach puts “health” beyond its original conceptual framework. All the activities and communications are geared toward a paradigm shift, especially in the following issues:

Holistic Health

“**Holistic health**” is different in concept from the kind of health that places emphasis on a narrowly scientific approach, especially on the physical aspect of health, leading to a fragmented approach to health. The most profound core of the reform attempts is to reform the thinking process. Therefore, health is a complete dynamic state of physical, mental, social and spiritual wellbeing and not merely the absence of disease or infirmity.

When health is taken to mean wellbeing, it relates to other considerations, including behaviours, genetic makeup, economy, family, community, environment, and culture. In this respect, health care reform shifts from the health service reform that focuses on hospitals and health stations to a community-based social reform.

Promotion of the learning process about wellbeing is not just about providing information and education but about interactive learning through action.

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Health as Human Right and Dignity

The 1997 Constitution has changed the perspective about the civil rights of the population. New rights are granted at several levels, including health. For instance, under Article 52: "A person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from public health centres of the State, as provided by the law. The public health service by the State shall be provided thoroughly and efficiently." Again, under Article 82: "The State shall thoroughly provide and promote standard and efficient public health service."

The draft National Health Act mentioned the rights to health from cradle to grave for all groups of people of all sexes, young and old. For example: "A person shall enjoy the right to live in the healthy environment and environmental conditions." "Personal health information shall be kept confidential." "The rights of certain groups of people, such as women, children, the elderly, and people with disabilities are protected." "People have the right to organize to manage health services on a self-reliant basis." Other rights included the right to die in peace and with dignity. In addition, the citizen's right came with his/her duty. The duty expected of the individual covered two main areas. Under Article 25: "The individual and family shall have the duty to promote their health and the health of the community. They shall be responsible for actions that may cause health hazards." Under Article 26: "The individual, family, community and State shall together have the duty to conserve, rehabilitate, and maintain traditions, local wisdom,

natural resources, environment and healthy environmental conditions.”

Health Security

Under the given definition of health, health security is part of the holistic wellbeing paradigm. This implies that there must be measures in place to protect and secure health for all people in time of good and ill health. When health is not yet in decline, there should be systems to promote health, control diseases and prevent possible health threats, as well as other health-enhancing measures. When in bad health, people should receive good, efficient and effective medical care and get easy access to healthcare, without incurring undue burden to the national budget and affecting other social securities.

Health security is an important foundation on which to build health activities and to use health resources. It is related to other kinds of security – social, economic, structural security, natural resource and environmental, access to healthcare security, justice, cultural, traditional and religious. Hand in hand with these securities, health security will be assured.

Sufficiency Health

The sufficiency health concept has appeared alongside other recent sufficiency trends, especially after the 1997 economic crisis. At the same time, health factors have begun to change including a population profile, diseases or health burden. People are living longer. More new and sophisticated technology is being used. All this causes health costs to go up.

Sufficiency health aims at revising and seeking measures to control costs and health consumption by generating knowledge and using it to change the thinking and behaviours of people concerned. It takes into account financial and fiscal measures that can be used as a dynamic instrument to change behaviours of service providers and users for the better. It offers more economical but equally effective alternative healthcares for people to choose. It also deals with the issue of the auditing system, including development of lists of essential drugs. With the auditing system, careful use of technology, and good-health-oriented approach, health costs will go down, thus truly benefiting the public health.

Health as Social Ideal

While national development is mainly geared toward economic competitiveness, wealth and prosperity, its downside appears in the deterioration of health, environment, culture, folk wisdom and local traditional lifestyles. The ill side-effects of development are quite common. The national health system reform tries to introduce new social values or ideals. No longer will development be focused solely on material outcome and economic prosperity; the new approach is based on **a healthy public policy**. Here, the public policy is not limited to the government sector. It includes the private sector, local organizations, community organizations and the people sector that are equal to the task.

The healthy public policy concept is based on the idea that all health decisions must come from the government,

private and social sectors. People's health is a top priority, while care must be taken to create and preserve good natural, social, economic and political environments. More accesses and alternatives to health care must be made available. In essence, public participation must be engaged in setting a public policy, assessing its impact and developing a **“Health Impact Assessment (HIA)”** tool. A public policy henceforth will be based on the participations of all parties concerned, especially the stakeholders, rather than the decision on considering what should or should not be done.

2. Opening up of Public Sphere for Participation with the “Triangle that Moves the Mountain” Strategy

The presence of the health assembly is based on certain assumptions. For participation to happen, the “public sphere” must be made available, where people can come together, freely express their opinions and manage the forums in whatever form they want.

The **“public sphere”** idea started in Europe in the 18th century when the government by absolute monarchy and under the influence of the Church and monarchs began to give way to democratic rule. It all started when people gathered in coffee houses, barbershops, or general stores to discuss contemporary issues. Eventually, the discussion turned to criticize the State. The bourgeois, mainly traders and capitalists, were major contributors who monitored the government's administration. Here, the “public sphere” was opposite to “the royal court” in which political decision-

making was closed to the public.

Today, we no longer depend on the forums to express our views. With advanced technology, we can talk without meeting face to face, thanks to such communication devices as newspapers, brochures, televisions, and even telephones. In the former time, coffee shops and streets might be the most popular places for the public sphere. Nowadays, the Internet is the modern largest public sphere where communication flows freely and seamlessly and where it is apparently the safest place to speak your mind. So, the Internet will feature more and more importantly in the global society. The modern public sphere, therefore, can be anywhere, any occasion and any time. Any mediated space, such as works of art, museums and cultural activities, could be called the public sphere if the issues to be discussed are public in nature and demand change.

In theory, the public sphere should be open to all groups without exception. In reality, however, practically no such ideal public sphere exists. There are even talks about how the public sphere is dominated or influenced by one interest group or another through various means.

The reason why the public sphere is used to drive the Thai health care reform is that in the past health issues and the direction health should take were taken up by a small number of people, mostly academics and health professionals. Decision was made more often than not by politicians or top administrators. When they stepped from office, the new administrator adopted another policy. Thus, there was little

"The triangular approach creates synergy that comes from constant interaction between the people sector, the academic sector, and the political sector – under the concept of *wisdom and reconciliation*."

or no continuity. The general public had no forum to share their decision making. They were in the most part on the receiving end of the government's decision. The plan made by the government health sector tended to be lacking in public acknowledgement, social capital value, and community wisdom. Relying mainly on the apparatus of government, it was not well integrated and often applied indiscriminately to every community.

The health assembly, therefore, serves as a “public sphere” where all sectors can talk about “health” in a collective manner and expect results through a series of activities including information sharing, public hearing, recommendation and action. It is diverse in its approach, involving modern technology, local culture, wisdom and lifestyles, facilitating a smooth exchange of views, under the **“Triangle that Moves the Mountain”** strategy. The triangular approach creates synergy that comes from constant interaction between the people sector, the academic sector, and the political sector – under the concept of “wisdom and reconciliation”.

3. Tools or Methods of Public Participation in Healthy Public Policy Formulation

The health assembly as a public sphere serves as a tool for public participation in healthy public policy formulation. This is similar to the methods of public participation that came to force after the 1997 Constitution. As a result of the Constitution, several organic laws and regulations were issued providing guidelines how the general public could

participate in the national affairs. The government identified three methods for public participation, i.e. public hearing, referendum, and public meeting.

Public Hearing

Public hearing is a large meeting formally organized as required by law. An agenda and time are set, allowing each party to present their argument systematically. An official record will be kept. The process is akin to a court hearing. The issues that require public hearing are: the State's project that may have serious impacts on the environment, culture, occupations, safety, and lifestyles or that may cause serious damage to the community or society and may lead to disputes from many quarters.

A decision to hold a public hearing is made by one of the following: **(1)** the authority holder (e.g. a minister or governor), **(2)** stakeholders, or **(3)** the public agency concerned. Once the decision is made, a public hearing committee will be officially appointed. An announcement will be made for the stakeholders to register within a certain period of time usually not less than 15 days. On the day of public hearing, representatives of the state agency concerned will first give the statement of facts and views on the issue, followed by experts or advisors, and finally by the stakeholders. The audience will then be allowed to ask questions, seek clarification, or give comments. Prior to the hearing, announcements must be made through various media, including radio and television. Announcement through the local newspaper must be made

at least 7 days in advance. As soon as the registration is complete, the public hearing committee is required to specify the issue for the occasion, group the participants and set the time slots for each group not less than 7 days after the registration. The stakeholders are required to inform the committee of the names of the group representatives not less than 25 days after registration. The committee is also required to collect all the necessary documents for public hearing and inform the registered parties of the public hearing date not less than 30 days after registration.


Referendum

A referendum is an event organized so that people can vote whether to accept or reject the issue in question without further comment. The fact that the people are asked to cast direct vote likens a referendum to a general election. Its spirit is based on direct democracy. When it is used in representative democracy, the referendum is changed in nature. It has become the government's instrument to get a project approved, since most, if not all, information presented supports the government decision. The referendum, therefore, is not definitive or final.

Public Meeting

A public meeting means an event at which people agree to meet at a certain time and at a certain venue in order to consider a number of issues together in an organized manner. It could be initiated by a people sector

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or a responsible organization. The outcome of such a meeting could be binding or unbinding, depending on its objective.

The public meeting could take the form of a conference, seminar, workshop, panel or panel forum, symposium or symposium forum, brainstorming, or a combination of different types. Often the outcome is not binding. Rather, it serves as a direct comment for the government to consider.

In Thai society, there are several other ways of participation, some being very traditional and age-old. The names may be different from region to region, e.g. “Sapha Ka-fae” (coffee-shop council) in the southern region, “Lan So Le” in the northeast region, and “Khuang” in the northern region. Other traditional activities, like the “Hauling the Buddha Image” ceremony or “Pole-Bearing” ceremony, could also be considered examples of public participation. The expression “Sapha Ka-fae” has been in vogue to such an extent that people take it to mean any informal political conversation or information-exchange forum.

However, the 1997 Constitution did not specify methods and procedures for public participation in detail; it had given rise to disputes on implementation. For instance, there was a common misconception that public participation was the same as a public hearing. Consequently, when one wanted the public to participate in anything, a public hearing was adopted using the regulation of the Prime Minister's Office as a processing criteria. So far there had been no serious or systematic study on public participation. A health assembly is, therefore, a creative novelty as a new method of

public participation allowing people to express their views freely and equally. So, over the past years the health assembly was based on the “public meeting” model.

4. Empowerment and Promotion of Civil Society Movement Conducive to Participatory Democratic Development

In its broader sense, health covers inter-related political, economic and social elements. The health reform process has been driven by the civil sector movement ultimately leading to people-centred governance.

In the ideal world “direct democracy” is the purest form of democracy under which a collective matter is decided by the assembly of all members who choose to participate. However, because of time constraints and a large number of members, direct democracy is not always possible. Most countries, therefore, choose “representative democracy” instead, allowing a subset of people to exercise sovereignty on behalf of the society. The question remains to what extent the representative decision is truly made on behalf of the society.

In more modern time participatory democracy has been widely accepted. The Thai Constitution of 1997 clearly reflected its origin in that concept, for it strived to give as much freedom and equality and as many rights to the people as possible, allowing them to participate in the political decision-making process at every level, local and national. It laid a foundation for the public to participate in the public policy process, ranging from access to public information, freedom

to express opinion, the right to participate in the decision-making process, right to take initiative, right to be part of the implementation process to the right to participate in the auditing process.

Effective public participation is made possible by the use of appropriate methods and a positive attitude shown by social sectors. On the other hand, if people in society are not empowered enough to feel that they own the issue or are too singular in their approach, public participation will never be as powerful as it should. A movement by a concerned group of people, known as “civil society”, is an important factor in the participatory democracy.

The idea about civil society arose when people began to feel that the State and the business or market sector unduly dominated the society and caused its structure to be vertical. In such a situation, the relationship that ensued was that between the power-wielding sector (the State and capital) and the powerless and dependent populace. Such social structure reinforced corruption, exploitation and fraud in society. It is often said that civil society is the “third power” after the State and the business sector. It represents the power that belongs to the people. The expansion of mass media and communications technology over the past decade has lent support to the civil society movement locally and globally.

Five factors conducive to civil society movement include: **(1)** the existence of civil society as an ideology, **(2)** an awareness of the people as citizens, **(3)** economic

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development or reform that reaches all sectors of the population, (4) promotion of research in psychology, culture and management, and (5) revision of laws, rules and regulations and promotion of more participation by the general public and civil society.

Civil society operates as a management network through cooperative efforts of many sectors, organizations and institutions for public goods. It has much to do with governance, not government. In other words, this is an opportunity for society to play a role in public policy management and democratic development.

It is estimated that there are approximately 50,000 transnational NGOs throughout the world. They hold about 5,000 world meetings a year. There are about 110,000 full-time workers and an equal number of volunteers. The budgets of these NGOs collectively are bigger than that of the United Nations.

These non-governmental actors in the new world order are collectively called "world civil society". Thanks to them, the problem of a specific locality can become a global issue transcending all national barriers. One of the most important benefits is that an ordinary citizen can have a say in setting the world agenda. In this manner, civil society is a form of "globalization from below".

While a national state and a business are run by its government and company respectively, civil society makes use of the world forum as an advocacy springboard for its


issues. The first World Social Forum was held in Brazil in 2001 with the theme “another world is possible”.

In such a world, no issue is local any more. Every matter can easily be part of a bigger issue made possible by modern information and communication technology.

The people’s power is what Joseph Nye calls “soft power” (Nye 2002), primarily based on general acceptance. All the agreements and rules tend to depend on what Mathews calls “soft law” (Matthews, 1997) usually in the form of manuals and recommendations rather than any hard law...The growth of civil society is, therefore, a growth of democracy at national and global levels.

(Source: Article entitled "Global Governance" (in Thai) by Chairat Charoensin-olan, Journal of Political Science, Year 26, Volume 1 (2005), pp. 1-49, Thammasat University Press, Bangkok)

The State and the people sector tend to view the public sphere and civil society differently. To the State, the civic movement is bent on opposing its power, while the academic and people sectors consider it a progressive cultural and political force. It is only an assembly of people to help set political and social agenda. There is nothing subversive about it. It aims to cultivate in the general public a new consciousness, to create a democratic political atmosphere, to politically empower the people, and advocate issues that may lead to changes in the mindset of the State and bureaucracy. It wants to see an individual's right and dignity guaranteed.




The community should be able to exercise its right to manage their resources, environment and lifestyles. Harmony and acknowledgement of diversity are encouraged.

The civil sector was introduced as a force to move forward the national health system reform and the health assembly process. The success and sustainability of the reform, thus, would depend on such coordinating bodies as the NHSRC and HSRO based on mutual understanding, mutual independence, flexibility, cordiality and voluntary multilateral networking. Cooperation was not confined to the relationship between two organizations. The health assembly would serve as the public sphere in which all reform partners, mostly from the people sector, learn how to voice their opinions in an intelligent, friendly and participatory manner.

- **Birth of Health Assembly in Thailand: From Academic Conceptual Framework and Recommendations to Practice and Learning**

As mentioned earlier, the health system reform has been underway for more than two decades. The first health assembly was held during 12-15 September 1988, at which a creation of the “health council” was proposed, but to no avail. However, when the national health system reform was re-launched, it never relinquished the ideology of public participation in the public health policy. The draft framework for the National Health Act recommended “health mechanisms at the national level”. The Health Systems Research Institute (HSRI) entrusted Dr. Churnrurtai Kanchanachitra, an academic



from Institute for Population and Social Research, Mahidol University, with the task of synthesizing the corpus of knowledge and developing a proposal on a mechanism and process needed to set a national health development policy and strategies.

According to Dr. Churnrurtai Kanchanachitra, Thailand has had its national health development plan since the Third National Economic and Social Development Plan under the responsibility of the Ministry of Public Health. However, it could not be considered a proper national policy, because an important element was missing, i.e. participation from all sectors concerned including the people sector and local communities. As a result, the policy lacked unity and coordination with agencies outside the Ministry of Public Health. The researcher, after conducting a series of interviews with experts and synthesizing the information from various literatures, came up with proposals about setting up a mechanism for developing the future national health policy as follows:

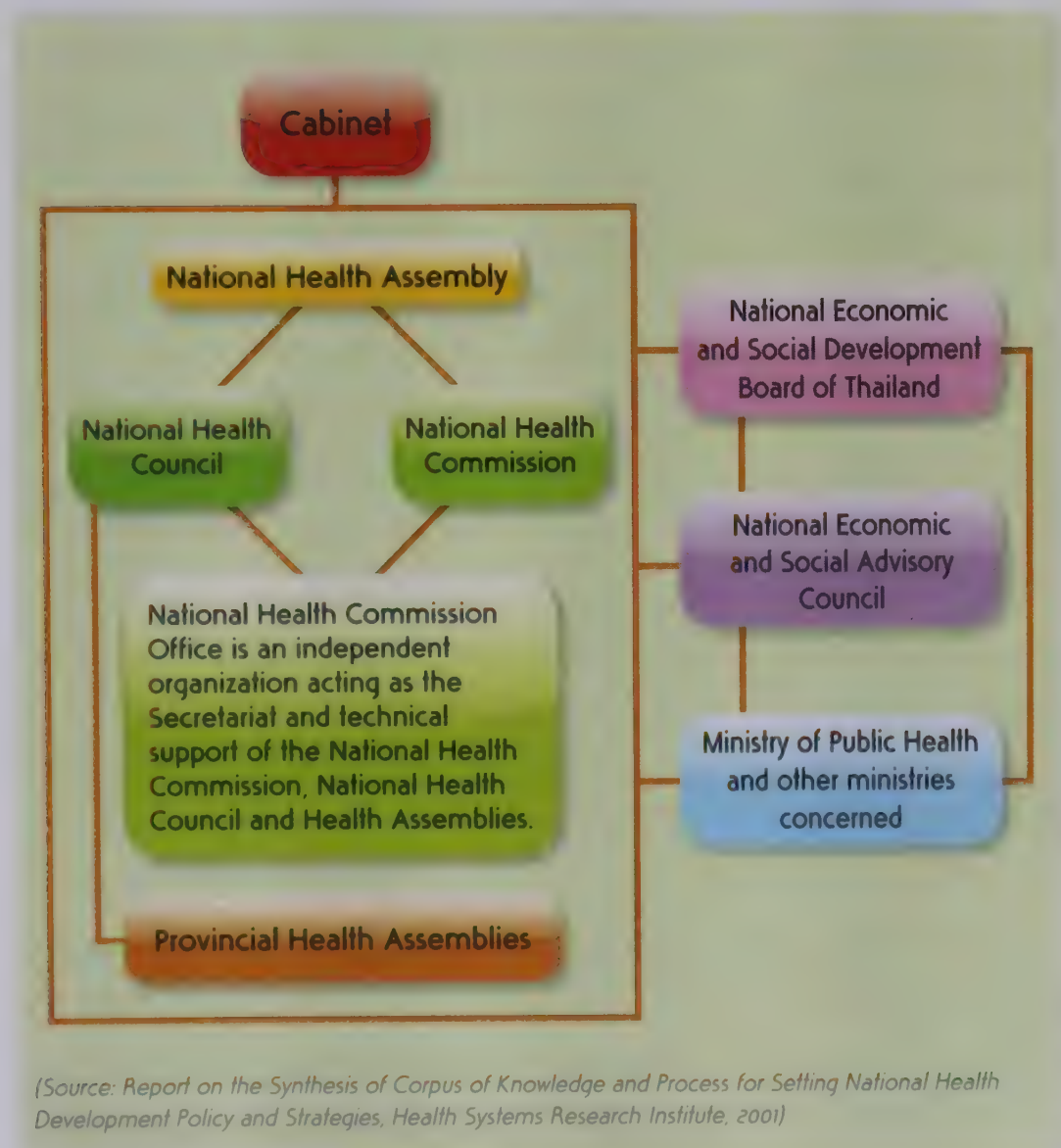
- The mechanism to be put in place must have an effective administrative structure. In other words, it must be a small organization, with sufficient flexibility and autonomy in its management, supported by the government's budget.

- It must have good governance, i.e. transparency, accountability, a work process based on consensus and responsibility and not on control and command.

- It must reflect participation from all sectors concerned working together as partners and reinforcing one another, thus creating synergy.

- It must have political accountability.
- It relies on wisdom and knowledge as a basis of work.

The first model included national and provincial health assemblies as important elements working with the National Health Council and National Health Commission.




The main functions of this mechanism were:

- To set the national health framework, short-termed, medium-termed and long-termed
- To make recommendations to and advise the government on health policy and health impacts as a result of various activities
- To provide stewardship or guidelines
- To propose a budgetary framework for implementation
- To create networks and coordinate between various agencies on health issues
- To act as the national centre on health knowledge through working with research institutes and collecting information from various agencies
- To monitor activities to ensure compliance with the policy
- To disseminate information, knowledge and national policy to the public

The study also recommended that "the health assembly" be a component of the mechanism and work alongside other components (the National Health Council Executive Committee and Office of National Health Council) as follows:

I. National Health Assembly would serve as governing body of the national health policy-setting mechanism. Its members would be drawn from representatives of the National Health Council and National Health Commission



(NHC). Its function would be to consider the national health policy and objectives before they were submitted to the cabinet for approval as a national policy.

Another function would be to coordinate with civil society to obtain views from every provincial health assembly. In this regard, it would serve as a forum for communication with various civil society groups in every province. It would also encourage the creation of provincial health councils as health partners. It would convene a meeting every year. The representatives of provincial health councils would be charged with inspecting and evaluating health policy and its impacts. Provincial health councils, therefore, would play an important part in setting the direction that evaluation will take.

2. National Health Council Executive Committee

would coordinate with government agencies, public-interest non-governmental organizations and qualified persons. The committee's function would be to supervise the performance of the Office of National Health Council along the line given by the National Health Assembly. (Actually, the office should not be the implementing agency but see to it that the policy is successfully implemented.) It would also supervise information sharing with government agencies at all levels, the general public, community and private sector. The committee would consist of representatives from government agencies concerned, professional councils, private sector, people sector, academics and qualified persons, with the director of the office acting as its secretary. The duties of the committee would be:

- To monitor and evaluate the work in line with a given policy.
- To make recommendations on health personnel production and research.
- To make an evaluation report on health situations of the country.
- To propose the country's health budget framework.
- To prioritize health problems.
- To make recommendations on mega-project investments and other policies that may have health impacts.
- To supervise the performance of the National Health Commission Office.

3. Office of National Health Council would coordinate with civil societies and government organizations. It would have an internal mechanism for education and research able to obtain information for analysis, evaluate health policy and other public policies that might have health impacts, and develop alternative solutions to health problems. The office would need to have an adequate budget for administrative and academic management if it hoped to advocate national health policy and create academic networks with education and research institutes both domestically and internationally.

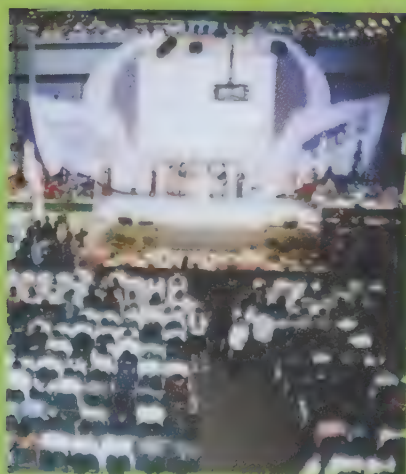
It was proposed that the National Health Commission Office (NHCO) be a juristic person responsible to the Prime Minister with the following functions:

- To manage health education and analyze health policy at national level and other urgent health problems
- To collect information and monitor the work in line with the national health policy
- To study national health costs within the budgetary framework
- To coordinate with the Ministry of Public Health and other agencies in implementing the health policy
- To prepare information and organize meetings of the National Health Assembly/National Health Council/National Health Commission
- To coordinate with the Office of National Economic & Social Advisory Council
- To disseminate health-related information and policy to the general public

“Thus, a Thai health assembly started with a concept gleaned from lessons from the world over as well as from books in the libraries and became active in the Thai social laboratory full of dynamic variables. It represented a new wave of learning amid the stream of national health system reform that flowed through time from generation to generation and was heading toward a new health system that would be more sustainable on the basis of public participation.”

2.

Four Years of Learning:
Health Assembly in Action



CHAPTER 2

Four Years of Learning: Health Assembly in Action

The health assembly came into being from an intellectual desire to see a Thai health system functioning by an independent mechanism through participation from the people, academic and political sectors. A national health policy should be the result of participation from all sectors concerned. The policy should respond to the health needs of the people – a principal goal of health system reform.

To move further, it was imperative that the mechanism empower the people sector and promote the growth of the civil society movement. Civil societies would move from acting singly to working as a network and between networks. In addition to health reform, the health assembly was expected to carry forward the intent of the 1997 Constitution, promoting participatory democracy, using health to trigger learning and collaboration.

"A conceptual framework for the national health system should be drafted as a model for brainstorming sessions in preparation for the drafting of the National Health Act."

"There had been concerted efforts to develop a national health policy based on the participation from all sectors concerned."

• Year 1 ★ 2001

Demonstration of the First National Health Assembly – Health System Blueprint

Soon after the National Health System Reform Office (HSRO) came into being, the National Health System Reform Committee (NHSRC) convened a meeting round November 2000 in Bangkok. It was decided that “a conceptual framework for the national health system” should be drafted as a model for brainstorming sessions in preparation for the drafting of the National Health Act. The framework drew on a number of regional and national brainstorming forums and other significant documents such as the 1997 Constitution, the national health report prepared by the Senate’s Standing Committee on Public Health, as well as findings and recommendations from various studies.

The draft conceptual framework served as “a blueprint” for the new health system. It was crafted by a technical team from the Technical Plan Section for National Health System Reform.

Equipped with the blueprint, HSRO then contacted various organizations, such as Health Network of People with Disabilities, Women Action Network, Traditional Thai Health Network, Network of the Poor, Network of I-san Local Sages, Network of Informal Workers, Medical Council, Nursing Council, Rural Doctor Society of the Ministry of Public Health, and Health Doctor Network, asking them to organize brainstorming sessions from provincial to district levels. More than 500 forums were organized. Recommendations

were then forwarded to the First National Health Assembly organized in the form of "Health (System) Reform Fair" during 1-5 September 2001. More than 150,000 people visited the fair while more than 5,000 registered for the special technical sessions and the health assembly.

1. The First National Health Assembly Demonstration: 3 Issues

There were three types of issues that appeared on the agenda of the demonstrated health assembly:

Specific Issues: health impact assessment of contract farming and Eastern Seaboard Development Project

Voices from Health System Reform Partners: recommendations from health partner organizations

Specific Recommendations on the Drafting of the National Health Act: recommendations and comments on the conceptual framework for the national health system on the basis of which the actual drafting of the act would be made.

The first ever demonstration of the health assembly was attended by the NHSRC together with its subcommittees and working groups, academics, qualified persons, and representatives of the community networks nationwide as well as the interested public. The representatives of the community networks were those already selected at the prior brainstorming sessions. The views of the partner organizations were presented by their representatives. Those who attended were required to pay registration fees. They included people who worked in the field or were directly affected by the health

system reform. They too could make their voices heard.

2. Declaration of the Recommendations on National Health System Reform

At the closing ceremony a number of representatives of the partner organizations for the national health system reform read out their commitment in various Thai dialects, including southern, northern and northeastern Thai, Yawee, and even hill-tribe languages.

Declaration of the Recommendations on National Health System Reform by Representatives of Partner Organizations

Wednesday, 5 September 2001

**IMPACT Exhibition and Convention Centre,
Muang Thong Thani
Nonthaburi Province**

Representatives from 237 networks of 1,524 partner organizations in Thai society, having regularly held, since 2000, meetings throughout the country in which more than 10,000 people participated, wish to make the following declaration:

1. National development shall be focused on creating wellbeing for the people and society alongside economic development.
2. The national health system shall emphasize the creation of wellbeing for all Thai citizens and societies and promotion of fair, effective and quality health care.
3. The national health system shall include a policy allowing the people sector to participate in a concrete manner,

a mechanism for knowledge sharing and a mechanism for interfacing with the political sector, thus ensuring an integrative health system.

4. The national health system shall include a health impact assessment of various public policies and an effective response to all such adverse impacts.
5. The national health system shall include channels for making possible the participation from all sectors concerned, facilitating decentralization, minimizing monopoly, promoting better understanding among people in society, sharing sufferings and benefits, caring for each other, refrain from taking advantage of each other, and promoting a belief that health is not meant for profit making.
6. The national health system shall attach great importance to protecting consumers, with an information system that is easy to get access to and able to empower the people in health issues.
7. The national health system shall promote and develop traditional Thai and local medicines, the medical systems based on Thai wisdom and practice, alongside Western and other alternative medicines so that people can have more options with a strong consumer protection programme.
8. The national health system shall include a universal health coverage system, finance system, and law and regulations system that promotes health promotion rather than an ill-health-oriented programme.
9. The national health system shall be based on a comprehensive structure to ensure health protection for the people and society and its ability to adapt to the changing problems and social conditions at all times.

“Over the past 13 years from 12 September 1988 when the public health assembly came into being, in 2001 the first demonstration of National Health Assembly was held, there had been concerted efforts to develop a national health policy based on the participation from all sectors concerned.

Dreams and commitments might not always materialize in a short time, but they were never abandoned, and there were loyal friends willing to carry on. The health assembly was kept alive, ready to take on new challenges that were on their way.”

• Year 2 * 2002

Three Networks – Winning More Allies: Hearing of the Draft National Health Act

As a result of the first demonstration National Health Assembly at the Health Fair in 2001, a large number of views and recommendations from participating partner organizations were collected and synthesized into “important substance to be included in the draft National Health Act”. They were further discussed at about 550 Amphoe (district) forums before they were included in the draft act. This people version of the act was considered at “provincial health assemblies” and “area-based/ issue-based health assemblies” and “national health assembly”. The objective was to raise social awareness and invite more participation in the drafting of the act as the assembly process progressed. People in the community were asked to analyze and recommend health actions. The people

"The people sector collaborated with local organizations to find common issues to be included in the draft National Health Act."

sector collaborated with local organizations to find common issues to be included in the draft National Health Act.

1. Area-based and Issue-based Health Assemblies

Small local forums were organized to consolidate the database of civil societies and their networks. These organizations were invited to contribute to health system reform in various guises. For instance, they could peruse the draft National Health Act and send their comments in writing. (This was the form commonly adopted by government agencies.) They could incorporate the consideration of the health act into seminars that they usually held. They could act as a node for forums at various levels ranging from small local to larger provincial forums. They could serve on the national committee/working groups, help organize health-promoting activities, or contribute in any other way to the drafting of the National Health Act.

2. Provincial Health Assembly

After the views and comments on the substance of the act had been collected, HSRO began to synthesize the “Triangle that Moves the Mountain” version of the draft National Health Act and the people version and submitted them to the “provincial health assemblies” during June-July 2002.

Objectives for the Provincial Health Assembly were Set as Follows:

- Objectives for “provincial health forums”

1. To hear comments on the substance of draft National Health Act.
2. To strengthen the learning process of the local community.
3. To collect lessons learnt and experiences with which to develop future health assemblies.
4. To promote learning conducive to the organization of area-based health assemblies.

- Objectives for “the organization of provincial health assemblies

1. To enable people in the local community to process and analyze health problems and assess community potentials.
2. To obtain ideas on how to solve health problems by a combined mechanism of the people sector and local organizations.
3. To use the draft National Health Act as a tool (a master plan) for solving local health problems.
4. To hear people's comments and recommendations on the draft National Health Act.
5. To generate the process and mechanism for the people sector in moving forward the draft National Health Act.

Management Structure

Organizing committees were set up to be responsible for national and provincial health assemblies. The national

organizing committee was chaired by Mr. Paiboon Wattanasiritham, while the provincial committee consisted of representatives from six sectors, i.e. the government sector, local administrative organizations, community groups (leaders of the health reform sector), academics, health NGOs, and community organizations in the locality. The total number of the members of the committee was between 15 and 20, with 5-10 advisers from various organizations. It consisted of three teams: management team, resource-person team, and record-keeping team.

- **The management team** was responsible for coordinating with partner organizations helping with the organization of the health assembly. It made known to the general public the impending health assembly and invited them to join. It also sent out invitations to various personalities in proportionate number and prepared the venue and other facilities.

- **The resource-person team** had the following functions:

1. To design the format of the assembly to integrate the participants and advocate the passage of the National Health Act.

2. To compile lists of individuals, groups and organizations interested in health issues.

3. To prepare health material and issues of the locality.

4. To coordinate processes and mechanisms whereby the people sector could solve problems found in the locality, leading to a continuous and sustainable development process.

5. To link the draft National Health Act to health problems of the population in the locality.

6. To organize the assembly and prepare a summary of important points for submission to the National Health Assembly.

-The record-keeping team was responsible for preparing minutes of the meeting and recording the atmosphere for the entire health assembly including the meeting process and observations. They would also work with resource persons in the summary and synthesis of each brainstorming session. The findings would then be presented to the National Health Assembly.

Summary of Common Characteristics Found in the Provincial Health Assemblies, 2002

	Common Characteristics Found in the Provincial Health Assemblies
I. Management mechanisms	<ul style="list-style-type: none">• Working groups consisted of representatives of diverse organizations. Attempts were made for health-related groups/communities/organizations in the same locality that had hitherto had little contact with one another to work toward the common goal.• Partnerships were expanded to include individuals and groups other than public health personnel, thus meeting the HSRO objective for a "multilateral" health assembly.• Several resource persons were not familiar enough with the contents of the assembly to explain or cite concrete examples or answer some of the queries that were raised at the meeting. Some forums, nevertheless, were quite strong in content matters, and despite one or two resource persons who did not do enough homework on the draft National Health Act, the assemblies were very productive.

	<ul style="list-style-type: none"> • Many assembly organizers did not fully understand the substance of the Act, the backgrounds of the chapters and sections. These matters were complex, thus making it difficult to come up with a good participatory process and reach the desired objectives. • Management was found to be most troublesome, especially if the organizers had never had experience in organizing a big event before, and found it difficult to deal with apparently small hurdles like light and sound problems and noise disturbance. This included controlling the atmosphere of the meeting and urging the audience to participate. Such problems, however, were less frequent when the organizers came from the government sector with more experience.
2. Assembly composition/presenters	<ul style="list-style-type: none"> • The assembly was diverse with 200-1,000 participants. Most participants were already the people sector's representatives in their capacities as kamnan (chiefs of Tambon or sub-district), and puyai ban (village headmen), Tambon Administrative Organization officers, and village volunteers. There were very few representatives from associations or groups with little social status who attended the assembly out of genuine interest. • The proportion of the presenters/discussants was not made clear to the organizers. As a result, on the day of the meeting there was an unduly long list of speakers, contrary to the objective and proportionality of the assembly composition. • As the number of participants was left open, depending on the available budget from HSRO and local support, there was a wide difference in each province's ability to attract participants and support. • Attempts were made to link with the government and political sector. Most assemblies would invite the provincial governors, top-level government administrators, such local politicians as Members of Parliament and mayors to chair the committees, act as advisers, preside over the opening ceremony, chair the hearing sessions, or receive recommendations and Declaration of Intent/Commitments from the assembly. The role played by the government/political sector depended a great deal on the organizers'

	<p>coordination skills and connection. Each locality has a different degree of such capacity</p> <ul style="list-style-type: none"> • Since the assembly was designed around the draft National Health Act, many forums invited lawyers to participate. The extent of their participation again depended the organizers' organization and coordination skills
3. Process/format	<ul style="list-style-type: none"> • The assembly took many forms, including brainstorming in special sessions and the plenary. Some forums came up with very interesting format. The members of the audience were very satisfied as they could express themselves freely and better appreciate the draft National Health Act • There were several factors affecting public participation. For example, a formal meeting tended to attract less participation. Undue attention to the titles and ranks of the speakers stopped ordinary citizens from expressing their views. The organizers and resource persons should have enough skills to stimulate the audience. Other factors include communications and communication tools, use of local dialects, listing and scheduling of speakers, activities/rituals, appropriate contents, making the most of the opportunity of people who aspired to play local politics, venue, food, travel, local social costs, relationship context, and strength of local community groups • Public communication was made via several media, especially for those who could not attend. The sessions were broadcast live through the Radio of Thailand station in the province or the locality concerned. Other media helped to make the event known to the general public.
4. Atmosphere on the stage	<ul style="list-style-type: none"> • A variety of cultural shows and performances were staged as an integral part of the assembly, including local drama at the assembly in Ranong Province, Lakhon-So Northern play, and I-san traditional Mo-Lam singing in the Northern and Northeastern provinces, their themes being the draft National Health Act. Klong-Yao Drum Dance was performed to arouse the attention of the audience before the technical event on the stage. Lae singing was also heard calling attention to the public rights and voices • Fairs or special events were held alongside the assembly, e.g. health festival, health fair. These events aimed to draw the public to the assembly and demonstrate a health-

	promoting-rather-than-cure approach in the light of the draft National Health Act. Such an approach was based on the model shown at the first demonstration health assembly.
5. Outcome	<ul style="list-style-type: none"> • Some assemblies obtained a clear and concrete set of health recommendations that could be applied to the locality right away, while others became venues for voicing complaints and grievances. All this depended on the intention and management skills of the organizers. • There were "commitments" or "social contracts" in the forms of a joint declaration of commitments/intents or a common logo for future use. These symbolic tokens were presented to the "authorities" who were supposed to implement them. A ritual was conducted to integrate the energy, mostly in the abstract form of awareness-raising rather than any concrete action. • The work of provincial health assemblies was further expanded. The assembly became a health mechanism in the locality with an "institution" status. The health assembly of Chiang Rai Province, for example, was equipped with a committee and working group as well as budget and its membership was on the increase.

(Synthesized by the Compiler/Editor)

3. Healthy Public Policy

In 2002 the Health Systems Research Institute (HSRI) began to advocate a "healthy public policy". The main aim of the healthy public policy was to create a supportive environment that could enable people to lead healthy lives through their participation in the decision-making process, including reviewing and monitoring the ongoing public health policy and mega-projects that might adversely affect society as a whole. It made use of an instrument known as "health impact assessment".

"The main aim of the healthy public policy was to create a supportive environment that could enable people to lead healthy lives through their participation in the decision-making process."

"It is a public forum for people from all sectors to exercise their power of mind, power of love, and power of goodness in health-related matters and to exchange learning between friends for a healthier life."

During the period when provincial health assemblies were being tried out, HSRI in coordination with community groups and non-governmental organizations in various localities organized about 10 issue-based health assemblies. The objective was to see how the draft National Health Act could solve existing problems or prevent potential problems from happening. The issues differed from locality to locality. For instance, the issue for the Maptaphub district, Rayong Province, was industrial projects, while Songkhla Province would consider the gas pipeline project, and Nakhon Nayok Province was concerned with waste water treatment.

Most issues reflected strong potential conflicts, and many had something to do with the government's national policy. Most participants had long been in the fray. The advocacy of the National Health Act helped to move their agenda forward, thus making the assembly excitingly intense. The experience of the organizing teams contributed to the prominence of the issue-based health assemblies. The year 2002 therefore was a good beginning for healthy policy development. The difference between an issue-based assembly and that in an area-based or a provincial health assembly was its academic approach.

4. National Health Assembly 2002

Agenda: Draft National Health Act

The second "National Health Assembly" was organized during 8-9 August 2002 with the theme "draft National Health Act" on the agenda. The issue was taken from the area-based

health assemblies. The slogan of the National Health Assembly was ***“Linking Networks, Expanding Partnership, and Concerted Efforts, on the Health Path”***.

The experience gained from organizing the first demonstration National Health Assembly (Health Fair) and provincial health assemblies was a tremendous help to the organizing team whose members came from various organizations and groups at national and local levels. The National Health Assembly was better managed with a clear and systematic framework and process design.

Role of Civil Societies in Management

The organizing team had started their preparation since May 2002, holding at least six meetings on a regular basis. The meetings took note of the outcomes of provincial health assemblies, area-based and issue-based health assemblies. Several team members went to observe some of these assemblies.

The organizing committee was chaired by Mr. Paiboon Wattanasiritham, chairman of Community Organizations Development Institute (CODI). Its members were drawn from a large variety of organizations: Mahidol University, Songkhla Community, Nakhon Si Thammarat Community, Ratchaburi Community, Southern I-san Community, Nursing Professional Community, HSRI, Khon Kaen University, and HSRO.

The organizing team was responsible for planning, setting the framework and ground rules of the meeting,

lists of participants, and overall management. There were other eight committees whose members were drawn from partner organizations. They held many meetings to agree on the division of labour. These were multilateral committees working in a spirit of camaraderie.

The members of the assembly were broadly classified in two groups. The first group consisted of representatives of agencies, organizations and reform networks from all corners of the country that had organized district and provincial assemblies. The second group comprised of members of the general public who had registered in advance free of charge.

In that year the organizing team summarized the concept of the health assembly as follows: ***“It is a public forum for people from all sectors to exercise their power of mind, power of love, and power of goodness in health-related matters and to exchange learning between friends for a healthier life.”***

The Three Sectors of the National Health Assembly 2002

The 2002 National Health Assembly saw a total number of 2,877 registered applicants, 2,000 more than planned. Of this number, 1,411 were from the community sectors in localities, and 347 from agencies under the Ministry of Public Health. It included interested members of the general public. Other interest groups were Women Action Network, Network of People with Disabilities, professional organizations, academics, general public, and politicians. The

organizing committee wanted to make sure that the assembly was proportionally represented by the people sector, government/political sector and professional and academic sector. Although it did not correspond with the frame set in the draft National Health Act, a large number of politicians and academics had shown a positive interest, thus auguring well for the future.

In general, the activities at the 2002 National Health Assembly could be classified into three groups:

1. Hearing on the draft National Health Act in the plenary and special sessions.
2. Rituals, ceremonies and show of force of the assembly in the plenary and on the central stage.
3. Activities promoting an exchange of learning and community potentials, including cultural performances and display booths.

Since the health assembly was a health-promoting process, a person who wished to express his/her opinion was advised to observe the following rules:

1. The message should be **intelligent**, i.e., based on knowledge or information rather than feeling or emotion.
2. The message should be **caring**, i.e., viewing the participants as friends, brothers or sisters who wished the society well without discrimination.
3. The message should be **constructive**, i.e., for the better and not turning the assembly into a combat ground.
4. The message should be **reconciliatory**, i.e., designed to bring people together rather than push them apart.

5. The speaker concerned should be **punctual**, i.e., coming to the meeting in time and not keeping others waiting.

6. The speaker should **adhere to the speaking time limit**, i.e. respecting the agreement and bearing in mind that others also wanted to speak.

7. The speaker should **respect and honour the audience**, i.e. with the assumption that all assembly members have equal dignity, whether they were Grade-4 graduates or doctoral-degree holders. Every voice counted and would be recorded for synthesis purposes.

Closing Ceremony

- From National Health Assembly

To “Concerted Efforts to Promote Health in His Majesty’s Footsteps”

At the closing ceremony of the 2002 National Health Assembly, NHSRO and partner organizations launched another project “Concerted Efforts to Promote Health in His Majesty’s Footsteps” aimed to bring about a changed lifestyle of the population. Emphasis was on self-care with the support from the family, community and all sectors concerned in line with His Majesty’s sufficiency economy. Thus, the end of the national assembly was the beginning of another project.

The campaign for the new project was scheduled between 1 October 2002 and November 2002. It consisted of three types of activities: ***finding the strengths of the health promotion partnership, staging five running and cycling events***

for good health in His Majesty's royal footsteps from the four regions of the country to Bangkok, and collecting signatures in support of the draft National Health Act. The roster of the signatures was later submitted to the House Speaker as a gesture of the wish of all Thai people to have "a national health statute".

- Social Contract: "Government and the draft National Health Act"

At the end of the 2002 National Health Assembly on 9 August, assembly members were all in good cheer that Prime Minister Police Lt. Col. Thaksin Shinawatra as the country's political leader came

To complete the "Triangle that Moves the Mountain" and to ensure the Thai Health Statute" would soon materialize, Prime Minister Police Lt. Col. Thaksin Shinawatra as the country's political leader at that time delivered a speech:

"The government, according to the principles of the social contract, is an agent that carries out its duty as required by the majority of people. That is the true philosophy of democracy. So, if it is the wish of the people to have the National Health Act and as health is no longer the responsibility of any one party or the government, it is right to do so. Therefore, the government's duty is to carry out the wish of the majority of people. It is only natural that the government will take this up to the executive and legislative processes."

“The experience and lessons learnt formed an important basis for future action. The National Health Assembly 2002 augured well for things to come, especially the timely passage of the National Health Act.

However, the perceived world and the real one might not necessarily be the same. The period after the 2002 National Health Assembly was beset with barriers that impeded the flow of health reform. NHSRC and HSRO unexpectedly were to have their terms extended.”

• Year 3 * 2003

**Exercising Wisdom and Loving Care for Common Solutions
: From Local Problems to Policy and Strategy
Recommendations**

The draft National Health Act was finally in the hands of the government. There was optimism about the social contract taken up by the Prime Minister and Minister of Public Health who acted as the third pillar in the Triangle that Moves the Mountain strategy. As time progressed, it was apparent that the draft National Health Act would not proceed as planned. The health assembly organizing committee met and decided to hold the 2003 health assembly. It would use local problems as a basis for discussion and policy recommendations for the government or sectors concerned. Issues from the Northern Region focused on

"The keywords of the assembly were wisdom and reconciliation. In other words, knowledge must form the basis of action and be translated into friendly advocacy."

"A health assembly should not be merely a forum for complaints or expression of sufferings without a practical answer. Instead, it should be a place for relief of sufferings, joy, creativity and intellectual stimulation."

organic agriculture and local health wisdom. Issues from the Central, Eastern and Western Regions covered three issues: holistic health service, public policies on energy and water, and alternative agriculture. Issues from the Southern Region took up the following: service system that would go well with the Muslim way of life and women's health; public policies that might affect health and the environment; tourism industry and local culture; alternative agriculture and environment; impacts of public policy and toxic chemicals used in agriculture. Issues from the Northeastern Region included alternative agriculture and environment and public policy on water management and the state of wellbeing.

There were also two specific issues that concerned the health system as a whole. One was health personnel for which the HSRI was to coordinate in the organization of smaller and national forums. The other was food safety for sustainable health for which the Office for National Food Policy and Strategy Development was responsible in the overall technical and management areas.

I. Focus on Academic Activities in Conjunction with Social Movements

In light of the lessons learnt from the last two national health assemblies, the keywords of the assembly were **“wisdom and reconciliation”**. In other words, knowledge must form the basis of action and be translated into friendly advocacy. **“Health”**, being a matter of general social concern, was used as the agenda.


The National Health Assembly Year 3 was, therefore, designed to be more technical in approach, taking into account all the findings synthesized from local assemblies. Academic or technical material would contribute to greater acceptance and further social action and intellectual movement. A health assembly should not be merely a forum for complaints or expression of sufferings without a practical answer. Instead, it should be a place for relief of sufferings, joy, creativity and intellectual stimulation.

Slogan of the 2003 health assembly was **“Exercising Wisdom and Loving Care for Common Solutions”**.

Although in practice academics and activists might not easily speak a common language, here they showed willingness to compromise and learn from each other. As a result, more networks were created to handle not only health but also other issues.

2. People Sector Joining Force

To prepare the 2003 National Health Assembly, HSRO requested Mr. Paiboon Wattanasiritham to once again chair the organizing committee. More members were appointed to serve the committees responsible for organizing assemblies in localities. The committee members recommended that government organizations be involved especially in matter concerning health policy decision-making. So, more members were appointed, including chairman of the Senate's Standing Committee on Public Health, chairman of House of Representatives' Standing Committee on Public Health,



Permanent Secretary for Interior, Permanent Secretary for Public Health, Permanent Secretary for Social Development and Human Security, Secretary-General of National Economic and Social Development Board, and manager of Thai Health Promotion Foundation (ThaiHealth).

However, the fact that more committee members were appointed from government organizations did not mean that they could fully participate or that the work would be better coordinated on a regular basis. On the other hand, all the names from the committees for organizing assemblies in localities were worthy of the cause. They all worked very hard preparing for the local as well as national health assemblies.

3. Aim to Support the Draft National Health Act

Amid a feeling of uncertainty, the government submitted the Triangle that Moves the Mountain version of the draft National Health Act to the House of Representatives on 24 September 2002 for consideration. During the eight months that followed, little progress was made despite constant inquiries. At the cabinet meeting on 21 January 2003 Prime Minister Thaksin Shinawatra gave an instruction that in view of the government's 30-baht universal health coverage scheme, some principles in the draft National Health Act needed to be reduced, arguing that the universal coverage had already taken care of the health issue to a certain extent. Besides, there was some concern about some provisions in the draft act that might affect the work of health and medical professions. So, to avoid conflict between the new health act

and the on-going health policy, the consideration of the draft act was indefinitely postponed by submitting to the Screening Committee for further legal consideration, while the three-year terms of NHSR and HSRO were due to end in August 2003.

The health assembly organizing committee and other community sectors were concerned about the future of the draft National health Act and the health assembly. The consultation that followed was not therefore confined to the organization of the 2003 National Health Assembly but also covered how to garner support for the draft act. Besides, what would happen to HSRO if the draft act was not passed in time? Would it be of any use to extend its term further? As to the health assembly, if the act was not passed and HSRO came to an end, would the local health assemblies or civil society sector be ready to continue the cause? What options should be adopted to move the National Health Act forward? The direction must be driven by the people to show that they were serious about it and that they wanted to see the health statute put in place.

All the above issues were intricately fused into one another and were often left unanswered by the meetings. The 2003 National Health Assembly posed a huge challenge. On the one hand, it needed to communicate to the general public, public and private sectors the merits of the draft National Health Act; on the other, it could come up with solutions to the people's health problems in the framework of the health assembly.

4. National Health Assembly 2003

The 2003 National Health Assembly was held on 7-8 August 2003 in Bangkok to discuss issues raised by the local/regional assemblies and assemblies on specific issues. This inter-regional assembly was attended by more than 3,000 participants, representing 70% of those who had attended the prior events. The rest were drawn from the NHSRC, qualified persons, academics on health and other related issues, government officials from the Ministry of Public Health and the general interested public.

It is noteworthy that there were few executives from public health organizations attending the event, especially those who would normally be seen at seminars, conferences or policy-oriented forums. The Minister of Public Health who had been approached to preside over the opening ceremony apologized for not being able to attend because of another important engagement at the last minute.

In short, the health care reform based on the “Triangle that Moves the Mountain” principle was supposedly to be driven by the people sector, while the government and political sector was significantly backing down.

However, with more than 3,000 participants, the 2003 National Health Assembly was still full of life and excitement, just like the previous years.

After the National Health Assembly 2003 ended, HSRI submitted the recommendations to the NHSRC. NHSRC, chaired by Dr. Purachai Piumsombun, appointed a committee to study the recommendations. The committee was chaired by

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Dr. Pairoj Ningsanon, with Professor Dr. Kasem Watthanachai and Ms. Srisawang Puawongpaet as vice chairpersons, and HSRO and HSRI as joint secretaries. Its objectives were to synthesize and screen recommendations. When the study was completed, HSRO notified to the communities, organizations and agencies concerned of the results, together with other follow-up activities to be taken on a regular basis.

In addition, the health assembly recommendations were submitted to the public health ministerial meeting for information. The meeting took note and decided to study them further. At the same time, the Medical Council, a significant professional association, became interested and set up a working group to study the recommendations as well.

“The apparent uncertainty of the Act situation, individual and conceptual differences looked set to weaken the third National Health Assembly. In a sense it was something of a disappointment; yet, something good came out of it. The attempts to monitor and advocate the proposed recommendations led to concrete results in several communities and localities based on academic cooperation and participation. They reflected the strength of the civil sector movement to move forward the agenda “healthy public policy” both directly and indirectly. These small successes smelt sweet for those who embarked on the long journey of the health reform.”

• Year 4 • 2004

Telling, Showing, Modeling

: From Policy and Strategy Recommendations to
Public Policy

After the National Health Assembly in 2003, two evaluations were conducted on its organization during the last three years, one by HSRO itself and the other by the HSRI that commissioned a group of academics to do the task. In addition, there were other forums discussing various aspects of the health assembly. All this paved the way for the 2004 National Health Assembly.

At its meeting on 21 November 2003, the NHSRC decided to hold health assemblies for the fourth year both at the locality, issue and national levels. Mr. Paiboon Wattanasiritham was once again appointed the chairperson of the 2004 Organizing Committee. The committee members were drawn from various sectors and organizations. From the ministries there were representatives from the Ministry of Public Health, Ministry of Interior, Ministry of Agriculture and Cooperatives, and Ministry of Social Development and Human Security. Members from organizations, groups and networks were the Office of National Economic and Social Development Board, Health Systems Research Institute, Office of Thai Health Promotion Foundation, National Health Security Office, National Health Foundation, Thailand Research Fund, Community Organizations Development Institute, Local Development Institute, Social and Health Research Institute,

Folk Doctor Foundation, Sustainable Agriculture Foundation, Foundation for Children, Consumer Protection Network, Local Wisdom Network, Network for Disabled Children, Network for People with Disabilities, Network of the Poor, Network of Informal Workers, Women's Health Network, Child and Youth Network, and Strong Family Network.

Members from professional associations included those from the Health Doctor Network, Medical Council, Nursing Council, and Pharmacy Council, while civic groups in each locality continued to work loyally for the health assembly cause. The event for 2004 drew even more attention than the years before, especially from government organizations and ministries. This was partly due to tireless efforts to monitor and follow-up the recommendations from the previous years.

On 21 October 2003, about two months after the 2003 National Health Assembly, the organizing committee met to prepare for the 2004 National Health Assembly. HSRO made an internal restructuring with plans to more effectively support the health assembly at all levels. It adopted the strategies of knowledge generation, knowledge synergy, and public media communication management, based on the experience of the previous years. Not only did it monitor the previous issues raised, but it also explored new issues in each locality, with a greater focus on children and family and health innovations.

In the fourth year of the health assembly, HSRO attached considerable importance to area-based/ issue-based

health assemblies. A multilateral database was developed and shared with its partners in the locality. The academic capacity of its multilateral partners was enhanced through greater cooperation with local academics. The office also developed a more systematic approach to preparations on the ground. Internal and external evaluations were prepared together with the lessons learnt. Quantitative, qualitative and process indicators were developed. There were two levels of working groups responsible for organizing the health assembly. One was the provincial organizing committee appointed by the provincial governor upon request of the NHSRC chairperson; the other was the organizing committee for the health assembly on a specific issue appointed by the chairperson of the Central Organizing Committee.

1. Searching for New Issues, Winning More Partners

The area-based health assembly used the same issue as the previous year as the basis for integrating with provincial and (sub)regional strategies as well as including such issues as child and youth health, family health and other current local problems. More issues meant more partnerships, for there were certain organizations already active in them. The health assembly, therefore, was an invitation to join more public forums.

With this concept in mind, each province came up with a creative but practical issue. In Sakhon Nakhon Province, for example, there were three groups of issues: (1) good health as a natural lifestyle, (2) toxic-free som-tam and lotus powder

(a natural taste-enhancer) made from natural leaves, and (3) environmental conservation. Some provinces combined health issues with other related projects. For instance, the Khon Kaen health assembly joined hands with a pilot research project “Food Safety: Khon Kaen Province” supported by Thai Health Promotion Foundation (ThaiHealth). The combined issue was named “Local Vegetables for Local Consumption” by local academics of the health assembly.


The issues at the locality and provincial level then became regional issues. For example, the provinces of Khon Kaen, Roi Et and Maha Sarakham, coming together as a group, organized an assembly on the specific issue entitled “Consumption for Good Shape, Happiness and Problem-free Health’. It served as a model of a local assembly working toward a policy level.

2. Embracing More Children and Youth

Three years of creating health assembly networks led to a creation of more active civil groups called by a variety of names, e.g. “Health Community”, “Health Reform Partnership”, “Provincial Health Assembly”, and “Network for Health System Reform”.

Some provinces saw the health assembly naturally integrated into the existing organization. In Trat Province, it became part of the Savings Group, originally created to solve local community problems and led by monks and other informal village leaders. In Saraburi Province, the health assembly joined force with the “Health-Promoting Group

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of Nongkatha" and village health volunteers. The group, encouraging physical exercises for health, was supported by provincial health, agriculture, and development officials as well as non-formal education officers.

The evaluation report of the Southern Region revealed that the success of the health assembly was due to the provincial preparedness as well as to the presence of other projects supported by the ThaiHealth. The provinces that were able to put forward a large number of activities and attract a large number of participants drew their additional financial resources from various projects, such as the research project on public life and healthy community.

Many local health assemblies were able to reach more students and young people. Provincial health assembly leaders felt that it was important to raise awareness among these groups of people about the health care process and environment conservation. The evaluation showed that the majority of the new members were happy to be part of the health assembly, part of the thinking and decision-making processes of something as important as health and life. Embracing this group of young people was good, but to involve them in a more meaningful way needed to be done on a regular basis.

Some provinces made an observation that the social context of the locality played an important part in how people thought and participated in the public forums. For example, in Suphan Buri Province, people felt that they had to be good to politicians because of a strong political patronage system.

They were unwilling to do anything of their own accord. Even local government officials dared not go against the wishes of the politicians. The fact that the people benefited from them made it more difficult for them to form groups and participate in activities for common good.

Several localities witnessed dynamic health assemblies largely because of existing social capitals or strong local wisdom. Provinces that were not as successful explained that when a letter seeking support for local assemblies was sent to the provincial health office, it was treated just like a routine request. In this case, the letter would be forwarded, for example, to a deputy governor, district chief, or local health officer, as the case may be, for further action. The situation was compounded by the inexperience of the assembly organizers in dealing with the government agencies. So, the health assembly concerned would attract little public attention or participation despite available social capitals.

3. Advocacy of Recommendations for Public Policy

To make recommendations materialize would depend on the participation and interest of the local policy makers as well as on the capacity of the assembly organizer. For example, in Nan Province, the recommendations were taken up and implemented in a concrete manner. Taking the issue of child malnutrition, for instance; the governor who was at the health assembly ordered a malnutrition survey to be undertaken and completed within two weeks so that appropriate action might be taken.

The assembly format differed from locality to locality. In some provinces the assembly was designed for the participants to express their views on predetermined issues, while in others the forum aimed to inform the audience of the work and outcomes of the networks after their meetings with provincial administrators.

On the whole, the assembly was held to take note of the recommendations made at smaller forums. Some provincial assemblies were focused on presenting policy and strategy recommendations to the participants for information and on how they would be implemented. Others wanted to present the recommendations made by various networks to those that supervised public policy implementation in the hope that some action might be taken. In most cases, however, the recommendations were not translated into policy issues. Very few found their way to the provincial health assembly through the participatory process.

There was an interesting case from Sakhon Nakhon Province. The assembly was organized in the dinner party format under the topic "From farm to dining table". Every dish served was toxic-free. The diners had the first-hand experience of eating toxic-free food and participated in the discussion that followed on the benefits of natural food, prevalent food safety or lack of it, findings of the survey on edible local vegetables, soil conditions, and polluted water. All this reflected very intelligent attempts to bring the recommendations to the attention of the responsible provincial social actors who were invited to the dinner, to

"Most happiness-generating innovations were ongoing forces waiting to be shared. In this regard, the assembly acted as a catalyst."

preside over the opening of the event, or to share their opinions. In this regard, these people would act as advocates, feel at one with the health assembly, and take up the cause further. The invited list included representatives from the provincial chamber of commerce, high-level government officials, Rotarians, elderly group, and retired civil servants. They could also help bear the cost of the dinner party.

However, despite the organizers' greater efforts to prepare area-based health assemblies, the results were not so tangible. Health assemblies in the fourth year varied widely in terms of the format used and quality, depending on each organizer. The point worth considering was how to improve the organizers or main coordinators to be more or less of the same high standard to ensure the quality of the assemblies while retaining their individuality. They should not be so uniform that they bore the stamp of any one institution.

4. Search for Happiness-Generating Innovation from Community

The search for happiness-generating innovation was an activity that ran parallel to the organization of the health assembly. According to the HSRO plan, each province should come up with at least one innovation that could be shared with others, thus generating more knowledge and networking. The plan was supported by the ThaiHealth.

Most happiness-generating innovations were ongoing forces waiting to be shared. In this regard, the assembly acted as a catalyst. Nevertheless, those innovations in the most part reflected experiences peculiar to one specific group

or individual. The sharing of learning, therefore, was rather limited. It was difficult to translate the experience of one individual or group into a public policy.


An example of happiness-generating innovation was found in Nakhon Si Thammarat Province where the experience was substantive enough to be duplicated. Some of the activities were physical exercises based on traditional cultural expression (using Manora dance gestures), “One Pea to the Community” project, and production of fiddler crabs for safe and quality consumption.

The provinces of Chumphon and Phuket, on the other hand, focused on food safety. They shared the local wisdom of producing toxic-free fruit and local dishes, as well as bringing to life community culture and history.

The Northeastern Region came up with “Nua” powder, a natural flavor and taste extract, and other activities. The search for innovation was the result of the assembly participation. When an issue was raised, a team of academics would study it in a deeper and more systematic manner. It went without saying that a province with a strong academic team, especially those from higher education institutes, was better equipped to synthesize the body of knowledge. All the discoveries were shown at the exhibition of the National Health Assembly.

5. “Good Citizen Operation”: Process that Moved Forward the Draft National Health Act

Advocacy for the draft National Health Act was given



green light by the assembly organizing committee with the people sector initiative. These civic groups met several times and set up a group drafting the people sector version of the National Health Act. The group formed part of the network for promotion of the people sector law under the Local Development Institute (LDI). With Mr. Paitoon Somkaew as the focal point, the network planned to collect at least 150,000 signatures in support of the draft act. This action was called “Good Citizen Operation”.

According to Article 170 of the 1997 Constitution, “the persons having the right to vote of not less than 50,000 in number shall have the right to submit a petition to the President of the National Assembly to consider such law as prescribed in Chapter III of the Constitution (Rights and Liberties of the Thai People) and Chapter V of the Constitution (Directive Principles of Fundamental State Policies.” As a result of this article, the Law Petition Act B.E. 2542 (1999) came into being. .

Within three to four months the networks in all areas collected 123,416 signatures and organized the first **“Good Citizen Operation”** for the world to see. The list of the names and the draft National Health Act were submitted to the President of the Parliament.

The good citizen operation was also linked to the closing ceremony of the 2004 National Health Assembly when a group of 99 health ambassadors were appointed to represent the health assembly and its partner organizations. The second good citizen operation took place before the

general election. All political parties sent their representatives to attend a forum where the essence of the people version of the draft National Health Act was explained to them. After this, the people sector organized a number of forums and activities in their localities before the general election. Finally, the people version of the draft National Health Act was tabled for consideration of the House of Representatives on 27 April 2005.

6. “Good Media Make Happiness”: Creation of Media for Creative Society

In 2004, HSRO launched a project called “Good Media Make Happiness”, a strategic innovation in public communication. It attached more importance to local media, which were secondary in nature, than the mainstream counterparts. HSRO wanted the project to be driven by partnership and geared toward the empowerment of the partner organizations rather than for its own sake.

The project was focused on developing potential local media where many media people still did not have a sound conceptual background. Mr. Surachai Chupaka from the Faculty of Humanities, Ramkamhaeng University was part of the training curriculum development team. The curriculum, integrating theory into the reality of the local media environment and equipped with a strong academic base, promoted the learning process about health. It made use of the substance of the health system reform and promoted the cooperation between the local media and local health

community. Various incentives were developed to generate enthusiasm, e.g. contest on “Good Media Make Happiness” in which the winner would receive an H.R.H. Princess Sirindhorn award at the National Health Assembly 2004.


The target group was three local media persons from each province, totaling 200 participants from every region. The objective was to produce a new breed of local media people who aimed to produce “media for creative purposes” or “media for wellbeing”. After a series of training, the recommendations made by local media participants were synthesized into guidelines for “Good Media Make Happiness” which also served as a policy recommendation for other media people to follow.

7. National Health Assembly 2004

The Organizing Committee met several times to prepare the 2004 National Health Assembly while monitoring other five area-based health assemblies for seven months. It took note of the strengths and shortcomings of the local assemblies to ensure the success of the national event. An additional workshop was organized covering a wider scope than the health assembly and attracting more than 100 participants.

The issues for the 2004 National Health Assembly, during 8-9 September 2004, were based on those of local assemblies and a continuation of the previous year theme. Together with the committee responsible for studying and monitoring the policy and strategy recommendations, the

"The 2004 National Health Assembly was more than a public forum for discussion. There were many formats to be seen, including performance, demonstration, exhibition, presentation of health innovations from different localities and community networks, exchange of knowledge, and replicas of health activities."



organizing committee decided on the theme of “Healthy Food and Agriculture” and the assembly motto of “Chemical-Free Agriculture, Toxic-Free Food, and Suffering-Free Life”. Other issues included learning about the community process and health, participation in the management of health security, and family of health assemblies.

The 2004 National Health Assembly was more than a public forum for discussion. There were many formats to be seen, including performance, demonstration, exhibition, presentation of health innovations from different localities and community networks, exchange of knowledge, and replicas of health activities. All this took place in an area called “**learning fair for wellbeing**”. There were 73 presentations divided into three zones. There were 19 presentations in the “good eating” zone, 17 presentations in the “good living” zone, and 37 presentations in the “happiness” zone.

More New Faces

Of 3,532 participants at the 2004 National Health Assembly, about 3,200 were invited by HSRO through community networks and partner organizations. The number of the nominated participants depended on the pre-arranged quota. A province could send 15, 18, or 20 representatives. The other 300 or more persons applied directly.

According to the registration figure, the proportion of the participants was 361 from the government and political sector (10%), 982 academics and health professionals (28%), and 2,189 from the general public or community sector (62%).

About two-thirds of the participants attended the event for the first time without going through an area-based or an issue-based health assembly or any health assembly for that matter. The phenomenon was due to a bigger coverage of the issues leading to a bigger network. On the other hand, some representatives from the provincial health assemblies had been exposed to some local health assemblies. They were at the national event to follow-up their recommendations.

As this year's target included children, youth and family, HSRO fixed the number for their participation – at least three children and youth from each province. A process was developed to help them learn about the assembly process through various activities.

Closing Ceremony and the Sending of Health Ambassadors to Monitor the Progress of the Draft National Health Act

A list of policy and strategy recommendations prepared by the technical working group was presented to the Chairman of the Closing Ceremony, Professor Dr. Pakdee Pothisiri, Deputy Permanent Secretary of Ministry of Public Health.

Then came a ritual of sending 99 health ambassadors to advocate and monitor the progress of the people version of the draft National Health Act. This was followed by the representatives of the assembly networks together announced their commitments to move forward and the closure of the National Health Assembly.

“Four years of learning with the health assembly were not just learning about wellbeing and the National Health Act but also about the empowerment of the civic sector to develop and set the directions of public policy together with the government sector from the local to national levels.

Nevertheless, the future of the health assembly remained a big challenge. How could learning bring about sustainable mechanisms for health policy development if HSRO, the main focal point, would come to an end as prescribed by the terms of the organization?”

Summary of Four Years of Development of the Health Assembly

Development	2001	2002	2003	2004
I. Concept and format	The health assembly was a formal mechanism with a fairly fixed membership consisting of representatives from every province. It had the duty and power to set, inspect, and supervise directions of the national health policy.	The health assembly was a "process" or public forum using a "wisdom and reconciliation" approach to obtain policy and strategy recommendations. The organizing committee and assembly members did not have a permanent status. At least 20% of the participants were from the people sector. The assembly recommendations were just recommendations and not binding.	The health assembly was a participatory process for a public policy, focusing on learning about principles of developing policy recommendations and monitoring their implementation through a technical/academic approach and linkage with the political sector and social movement.	The health assembly was a process through which the people and government sectors concerned exchanged knowledge and learning through wisdom and reconciliation, leading to a healthy public policy. It was a systematic and participatory forum, featuring a public discussion and collecting health issues from localities, health-promoting techniques and effective communication channels with society.

Development	2001	2002	2003	2004
2. Issues	<ul style="list-style-type: none"> • Draft conceptual framework of national health • Effects of the State policy on health: two projects 	<p>Draft National Health Act and public policy that had an effect on health</p>	<p>Six health issues emerging from area-based and issue based health assemblies and relating to the essence of the draft Act</p>	<p>Issues carried over from 2003, focusing on safe agriculture, toxic-free food, and ten other specific issues</p>
3. Management mechanisms	<p>NHSRC and HSRO were the focal points of coordination and cooperation with local and specific networks.</p>	<ul style="list-style-type: none"> • The health assembly organizing committee was represented by the participating networks/community • The local assembly committee was multilateral in nature. • The special sessions at the National Health Assembly were mainly managed by an academic team from the central body. 	<ul style="list-style-type: none"> • More representatives from the community groups were members of the assembly committee. Working groups in localities were formally appointed. • Efforts were made to invite government agencies to participate, albeit with little result. • The local assembly committee became even more multilateral. There was more cooperation with local academics. • At the National Health Assembly leaders from local assemblies played a greater role in managing their issues in the special sessions 	<ul style="list-style-type: none"> • The central committee had more members from the government agencies. • More efforts were made to develop the potentials of the members of the local assembly organizers • More energy was devoted to technical/academic aspects and the evaluation system. • The partner network was further expanded to accommodate new issues at the National Health Assembly

Development	2001	2002	2003	2004
4. Process	<ul style="list-style-type: none"> • About 500 forums were held at district and provincial levels throughout the country. • There were about 300 participating groups/networks. • Representatives from 53 groups/networks at local assembly level participated in the first demonstration National Health Assembly where they presented their comments on the draft conceptual framework. • The process of the demonstration health assembly was rather formal. • A health fair was organized, attracting many people. 	<ul style="list-style-type: none"> • Seventy-five provincial health assemblies were held in various formats, including meetings, seminars, public and local forums. • Art and cultural performances formed part of the provincial and National Health Assembly. • The provincial forum featured health fairs, exhibitions, and group physical exercises. • At the national health assembly special sessions were organized around chapters of the draft Act. Their findings were then presented to the plenary. The atmosphere of the public form was non-academic. • An area was marked as the assembly ground where all good things necessary for health were displayed. 	<ul style="list-style-type: none"> • Local health assemblies were organized as regional grouping. Each region designed its own process, holding forums in every province, sub-regional forums, or one single regional assembly. • Two issues were taken up by health assemblies on specific issues. • Art and cultural performances were an integral part. • At the National Health Assembly special sessions were organized according to issues. Their findings were then presented to the plenary on Day Two. • An area was designated as the assembly ground. 	<ul style="list-style-type: none"> • Local health assemblies were held as provincial grouping with common problems/issues. • The process of the local health assembly did not yet have a definite format or quality standard, depending on the organizers. • The health assemblies on specific issues came up with 10 issues and were able to develop very clear recommendations by making use of the special sessions and participatory process. • Signatures were collected to petition the people version of the draft National Health Act. • A "Good Media Make Happiness" project was launched. • Day One of the National Health Assembly was devoted to the main issue "agriculture and food"

Development	2001	2002	2003	2004
				<p>divided into four special sessions. The findings were presented to the plenary in the afternoon. Day Two was devoted entirely to consideration of 10 issues in special sessions.</p> <ul style="list-style-type: none"> • There was a learning fair for wellbeing.
5. Important outcome	<ul style="list-style-type: none"> • Joint Declaration of Commitments/Intentions • Recommendations synthesized for the draft Act 	<ul style="list-style-type: none"> • Prime Minister attended the event, was given a list of recommendations and promised to move the draft Act forward. • A health-promoting project in His Majesty's Footsteps was launched. 	<ul style="list-style-type: none"> • An idea was suggested to collect signatures to petition for the people version of the draft Act. • The assembly came up with a list of policy and strategy recommendations that it hoped to see implemented. The efforts were to be backed up with more technical/academic work. • There emerged mechanisms to monitor and move the health assembly recommendations forward. 	<ul style="list-style-type: none"> • Recommendations on various issues raised by the assemblies were implemented as a result of working with various agencies and organizations and inter-agency cooperation. • Attempts were made in the localities to recommend and advocate public policy further.

"In my view a health assembly is a social process. The question is whether the events in the past have rendered it into a system or mechanism for future health assemblies. If you asked me, I would say "Yes, to a certain extent". If we can bring the management and learning capacity to the local level, it will be even better. To do so, there must be a mechanism in place for the community to be self-reliant. I am thinking of a natural mechanism of local management in which learning takes place continuously. With the presence of a local mechanism, the foundation will be set. If the mechanism at the upper level lends its impetus, coupled with the strength and diversity of those at the lower level, it will be complete. The mechanism at the middle level is easy to materialize, for it could be HSRO and any agency that can take over. The mechanisms at the lower level are harder to come by."

Mr. Paiboon Wattanasiritham

Chairman, Organizing Committee of 2001-2004 National Health Assembly

"The health assembly process relies on a discourse on happiness or health promotion. It is not designed to scrutinize the government sector and does not share the same fate as the assembly of the poor and others that come under heavy attack despite their good intentions. So, its discourse and concept play a very important part here. Beside HSRO, there are other players in the field, individuals, organizations, and networks. I can see that HSRO is capable of creating networks, but we cannot expect

to see them all reach the same high standard and target. The health assembly must move forward in an academically-oriented fashion rather than acting as an auditing agency. Those who have been there should summarize the lessons learnt and engage new players.

With regard to the draft National Health Act, I am not certain whether it will be passed and put into effect. HSRO should not wait for this to happen. Rather, it must translate the implications found in the draft Act into something practical and concrete and show the world all its splendour. It must continue to advocate for the political sector to appreciate its significance. At the moment, politicians do not understand the National Health Act, not even the Opposition.

For example, the approach to the healthy public policy is praiseworthy in its attempt to bring knowledge management to the community. In the past, the community preferred to put pressure on the State. The new approach intends to link together academics, people and government agencies in the locality. It is a very good approach though many academics may feel that this is not their cup of tea.

On public communication, do not forget that the mainstream media have all been taken. We must pay more attention to community media. Most importantly, the health assembly should focus on the issue of participation in the policy development. Do not start with scrutinizing the State policy or its use of power.”

*Dr. Nirun Phitakwaichara
Member of the Senate, Ubon Ratchathani Province*

3.

Policy and Strategy for Wellbeing:
National Health Assembly 2005



CHAPTER 3

Policy and Strategy for Wellbeing: National Health Assembly 2005

After a learning process during four years of the health assembly development and a great leap towards the draft National Health Act (the Triangle that Moves the Mountain version had been finally approved by the cabinet and submitted further to the Council of State for consideration and amendment before being submitted to the Parliament; whereas the people version was submitted to the House of Representatives as a new agenda item for consideration), the fifth National Health Assembly was organized during 7-9 July 2005 in Nonthaburi Province, in accordance with the spirit enshrined in the draft National Health Act (Sections 38 and 39*). In this connection, the National Health Commission (NHC) set up a committee responsible for organizing an

* Under Section 38 the people can come together to organize a health assembly in a specific locality or on a specific issue in accordance with the rules and procedure prescribed by NHC.

Under Section 39 NHC shall organize a national health assembly at least once a year.

(taken from the bill considered by the Council of State on 21 June 2005)

"The concept of turning the crisis in the southern region into an opportunity for wellbeing is based on love, faith and understanding, being open to religious and cultural diversity of fellow beings, equipped with more open social space, helping to create positive activities and new learning in a constructive atmosphere, minimizing distrust, acting on basis of community participation, with an extensive network linking to the policy at every level, leading to a society of reconciliation."

assembly, with Dr.Banlu Siripanich as the Chairman, under the theme “For Wellbeing”. Besides the plenary, the National Health Assembly was divided into 12 different special sessions each discussing topics based on various area-based and issue-based health assemblies, including those carried over from previous considerations and those proposed by other partnerships.

The manner of deliberations in each special session took many forms including discussion, exchange of opinions, and presentation of real-life cases. The outputs, a result of well-thought-out and analytical processes, became the basis for Policy and Strategy Recommendations for further action leading to a healthier and happier life in Thai society.

Hundreds of ideas expressed in the health assembly process were analyzed and crystallized into a summary of recommendations on policies and strategies for wellbeing.

• Policy and Strategy Recommendations

1. Turning the Crisis in Southern Region into Opportunity for Wellbeing

- The Government should support the opening of social space for positive activities and new learning, create an atmosphere of reconciliation and minimize a sense of distrust, with the priority given to speedy economic assistance based on community needs.


- Local Administrative Organizations should coordinate and support education and development mechanisms in

"- We should talk social workers into returning home and spending more time with their family.

- We want to see more exchange forums in the communities. If anyone has a happiness-creating process to share, please share with one another.

- Education institutes and government offices should be used to foster greater happiness and conflict resolution.

- A declaration of intent will be announced, whereby all partners will form into a family and will be friends no matter where we are. Then, a central working committee will be established to coordinate and move the agenda further."



local communities on the participatory basis, supporting the community in its attempts to organize and manage itself.

- The community should initiate positive activities in line with its interests when opportunity arises, put in place a learning process that is linked to networking and policy coordination at every level, and develop communication channels within itself and with public media.

- The family should foster love, faith and understanding, open to cultural diversity and determined to bring its members to understand the essence of each religion.

- The private sector should take interest in public problems, form an alliance of operational networks, and learn together with the community on how to support community-based activities.

- The research sector should be action-oriented, able to create an extensive learning process and body of knowledge at the same time.

- The mass media should present positive activities in a positive light, serving as a learning model for society and at the same time reducing social distrust.

2. Power of Children, Youth, Family and the Elderly or Wellbeing

- There should be more coordination and support from the Government for working with the people sector, especially in the area of social and family work.

- Local Administrative Organizations, especially Tambon Administrative Organizations (TAO), must survey, assist and support various groupings/organizations working in their areas.

- Community groups should be formed and coordinated with other networks of the people sectors to exchange learning and advocate the issue together.

- Positive-oriented conversation should be promoted, thereby fostering a new family relationship in which “listening” is more important than “speaking” and each family member focuses on developing a positive approach to positive-oriented conversation.

- A lead agency should be created to support, assist, coordinate and introduce interesting innovations as learning models.

- Existing media channels should be further utilized and more innovations of value should be disseminated to all people on a regular basis.

3. Food and Farming for Wellbeing

On Supporting a Healthy and Environment-Friendly Agricultural System

- The Government should create incentives for good production, making it possible for prices of organic farming products to be lower than general goods and for farmers to receive an appropriate return while the government will absorb the price differentials.

- The Government should promote knowledge management process and exchange of knowledge on sustainable agriculture, focusing on conceptual change, fostering an honest work attitude, drawing on the farmers' existing knowledge, applying new knowledge, and making full

use of local wisdom.

- The Government should set standards for a wide range of organic fertilizers and promote the production of local bio-fertilizers. If the fertilizers are to be commercially produced, standard inspection must be made available quickly, thus facilitating local production.

- The Government should cancel the agricultural policies and projects that go against the organic farming policy, e.g. policies to promote the planting of rubber, oil palm and GMOs.

- Local Administrative Organizations should consider providing budgetary support for community-based organizations as well as for the community where sustainable agriculture is practiced.

- Local Administrative Organizations should support the use of various funds in the community in the interest of sustainable agriculture.

- Agricultural Education Institutions should put in place courses on chemical-free and organic agriculture, drawing on the knowledge and practice of successful communities.

On Controlling Advertisement and Sales Promotion of Agricultural Chemical Fertilizers

- The Government should announce the cabinet's resolutions that forbid advertising agricultural chemicals in the media on the same standard as the banning of advertisement of alcohol and cigarettes and that require the advertisement to specify the dangers that come with the use of agricultural chemicals.

- The Government should forbid the advertisement of agricultural chemicals in the highly toxic category (Ia, Ib) in all media.

- Labels of agricultural chemicals must carry large enough wording, with sufficient space containing equal information on their benefits and dangers.

- The Government should allocate time for the government's public media to promote sustainable organic farming and chemical-free agriculture of all types as a proactive approach.

- The Government should review Hazardous Substances Act BE 2535 (1992) and make it illegal to offer all kinds of promotion, including price reduction, product redemption, giveaways, and "buy one get one free" offer, aimed to boost the sales of agricultural chemicals. Although the practice is not illegal at the moment, it is unethical.

- The Government should strictly enforce the laws, especially those dealing with the uses of chemicals that have been cancelled and those governing the sales of agricultural chemicals by licensed dealers. Currently, violation can be seen in direct sales, in shops or department stores where such chemicals are sold alongside other commodities without proper license.

- Local Administrative Organizations should act as the main agency for monitoring and controlling agricultural chemicals, exercising the invested authority by issuing bylaws to govern the advertisement and promotion of agricultural

chemicals. For example, billboards and posters advertising agricultural chemicals are allowed only in and limited to certain designated areas. Such designation must involve community participation. In addition, no authorization is allowed for advertisement of all highly toxic agricultural chemicals.

- Community groups should be formed and make recommendations to Local Administrative Organizations to issue bylaws controlling advertisement and sales promotion of agricultural chemicals in the community.

- The Community and the Civil Sector should adopt the attitude of self-reliance as much as possible and raise awareness of dangers of agricultural chemicals.

On Controlling and Monitoring Agricultural Chemicals

- The Government should designate a lead agency directly responsible for managing chemicals.

- The Government should put in place measures to compensate people who are affected by or fall victim to agricultural chemicals.

- The Government should forbid the importation of agricultural chemicals the residues of which cannot be inspected.

- The Government should put in place legal provisions to govern and supervise the effects of agricultural chemicals on the environment, e.g. quality of water and soil. To start with, the provision should be included in the Bill on Water Resources which is being drafted.

- The Department of Highway should not use spray the areas near the highways with pesticide.

"Food and agricultural systems for wellbeing will be possible only when all sectors adopt a common approach of giving and sharing and help stop dangers from pesticide by forbidding all kinds of advertisement, controlling all types of sales, and banning importation of all highly toxic chemicals.

The crucial actors are the community and local administrative organizations. They must start their work from within, by jointly setting measures to control and monitor the use, sale, advertisement and sale promotion of chemicals in their own community."

- There should be such volunteers as community leaders, sustainable agriculture organizations and consumers to act as watchdogs and to monitor any legal violation concerning agricultural chemicals, e.g. sales without a license, as well as notifying the officials of local administrative organizations for further legal action.

- The Community and the Civil Sector should jointly set the community rules in the monitoring and control of agricultural chemicals, as a result of which there will be some model communities where advertisement of chemicals is properly controlled.

On Food Safety Systems

- Taxes should be imposed on imported agricultural chemicals, the revenue of which will be used to set up a fund to support the management of food safety, sustainable agriculture, organic farming and all agricultural practices.

- Local Administrative Organizations should create alternative markets at community level where consumers can buy good agricultural food and products, for example, by setting up certified food stalls in the markets supervised by the municipality or local administrative organization.

4. Local Community and Establishing Health Insurance for Wellbeing

- The Government should review fiscal and financial rules and regulations, organizing meetings between agencies of the Department of Local Administration, Ministry of Public Health and Ministry of Finance.

"It's about time that we, the people sector, local administrative organizations and the local public health sector in the well-prepared areas, would possess desirable health and bring about good health for all from 2006 onward.

If the support we are given comes truly from the heart, there is a real chance that the attempt to advocate and manage the health system on the basis of wisdom will eventually bring about wellbeing and good health."

- Local Administrative Organizations should set up a number of posts intended for students of the special projects from the areas where concrete budgetary support is most likely.

- The Community should create ways and means for participation in the fund, resources, wisdom and management.

- The Community should create awareness for the love of hometown.

- The Community should share happiness and suffering.

- Family should adhere to self-reliance and self-care in health matters

- Family should adopt the strategy of honesty to self, family and community

- Related organizations should expand coalition and create an extensive network of alliances including monks, local wise men and women, and local agencies.

- Mass media should create and raise awareness for participation at all levels.

- Research should conduct study on people participation that leads to wellbeing.

5. Public Life and Healthy Community for Wellbeing

- People should become more aware of and more alert to the world's situations that may impact society at every level.

- The establishment of public media that enable people in society to think and reflect carefully in all dimensions should be promoted and supported.

"A healthy public life is a state in which people in the community feel its ownership, are aware of their tie with the community, have a common understanding of the situation, accept the differences and diversity, feel that they share a similar fate, and appreciate the importance of inter-dependence.

A healthy public life is made possible under the basic assumption that *society will be improved with a greater level of learning and awareness of its citizens. If a society has good public life, it will be conducive to a healthy life and a society of wellbeing.* All this requires an operational network with a participatory approach to thinking, decision making, action, benefit and learning in an integrated manner.

Hence, *a state of wellbeing.*"

- Laying the foundation for turning knowledge-alert people into change leaders in sufficient numbers who can be adequately absorbed by organizations on a regular basis should be focused.

- Local strategies must take into account cooperation of various partners in the community.

- The government sector must create/open up an opportunity for the civil sector to have forums to exchange opinions and dialogue and to facilitate mutual social learning through forums when significant public issues arise at the local and policy levels.

6. Local Administrative Organizations and Participatory Public Policy Process for Wellbeing

- Every Local Administrative Organization should systematically conduct a health assembly process at local level from the pre-assembly phase to the assembly and post-assembly stages.

- Local Administrative Organizations should provide budgetary support for the organization of the health assembly and for the policy and strategic plans in which the villagers have participated.

- Local Administrative Organizations should cooperate with education institutes, the community and non-governmental organizations, requesting their support for the development of the health assembly process.

- The National Health System Reform Office should cooperate with the Department of Local Administration,

"The Department of Local Administration is a very important grassroots organization that helps strengthen the community especially in fostering the wellbeing of the local people. One of its important tools is the participatory public policy process in which every party from the people sector, local administrative organizations and the academic network contribute to the development and implementation of activities to meet the wishes of the community or local people."

associations, leagues and various groups under the Tambon Administrative Organizations (TAO), municipalities, and Provincial Administrative Organizations (PAO) in the campaign to seek cooperation in the organization of the local health assembly process throughout the country.

- Tambon Administrative Organizations, municipalities, and Provincial Administrative Organizations should support plans and budgetary requests from the local health assembly process.

- Tambon Administrative Organizations, municipalities, and Provincial Administrative Organizations should put in place mechanisms that facilitate the implementation of policies, strategies and plans coming from the Health Assembly. Such mechanisms include the establishment of a health commission, working together with the community, and the allocation of personnel responsible for health plans as part of the work team.

- The community and people sectors should immediately implement the plans that they have developed and work together to mobilize funds in support of the health plan that every party concerned has contributed to.

7. Potentials of People with Disabilities for Wellbeing

- The Government should primarily provide facilities to meet the needs of various types of disability, e.g. orientation and mobility (O&M) resources, personal assistant (PA) services and other learning equipments.

- The Government should set up alternative service

"The rehabilitation of people with disabilities and development of their potentials through providing personal and material facilities and systems according to the type of disability will form the first window to good health for people with disabilities, their families and the community as a whole. All this is done on the basis of exchange of learning and first-hand experience through activities that reflect creative potentials of people with disabilities."

centres for people with disabilities, e.g. Independent Living (IL), Orientation and Mobility Centre, Pithak Sit House (Rights Protection House), and Interpretation Service Centre.

- Local Administrative Organizations should support and encourage the formation of groups of people with disabilities and parent groups for self-help.

- Local Administrative Organizations should put in place various systems that promote community-based learning, rehabilitation and development, making use of such institutions as monasteries and schools and involving the participation of people with disabilities.

- The Community should promote learning about the symptoms and behaviours of each type of disability in the community.

- The Community should advocate disabled care as part of the school curriculum and disseminate the knowledge to society.

- The Family should encourage learning from the lesson learned, experience, knowledge about childcare and disabled care and disseminate the knowledge to other parents.

- The Family should promote various types of activities designed to provide spiritual support for family members, e.g. quality time and expression of loving care to one another.

- Various disabled organizations can join the advocacy campaign.

- Disabled organizations must come up with clear activities that can be measured, assessed and expanded.

- Mass Media should provide air time for teaching,

training, care of children with disabilities on radio and television.

- Research and to Mass Media should make known to the general public the potentials and lessons about people with disabilities.

Declaration of Intent

Subject: Provision of facilities for people with disabilities and the elderly in the public area, submitted for consideration to the 2005 National Health Assembly

As the government's national health system reform policy is based on the participation of the people sector, the Health Network of People with Disabilities, having faith and confidence in such a policy and consisting of people of disabilities from all sorts of disabled organizations including the network of the parents of people with disabilities, academics, and partners from various health-related communities all over the country, has therefore participated in the development of policy and strategies on the wellbeing of people with disabilities ever since 2001. It is found that "provision of facilities for people with disabilities" is a common issue in all forums, regarding disability of all types and levels.

Besides, this year, the issue of "wellbeing" is a new development target that attracts considerable interests and attention. The process of developing "people with disabilities"

toward such a goal will be possible only when one can do away with various obstacles to social participation of people with disabilities. Other actions include measures to encourage and promote the environment conducive to such participation in every possible way on the basis of reality and possibility so that people with disabilities can be part of the movement to turn Thailand truly into a society of wellbeing.

In this regard, the Health Network of People with Disabilities agrees to be part of the campaign to mobilize and advocate for all sectors concerned to "provide facilities for people with disabilities and the elderly in the public area", thus ensuring equality and social justice as well as greater access to health services for them and the elderly in line with Articles 4, 54, and 80 of the Constitution and Act on Rehabilitation of People with Disabilities BE 2534 (1991) and National Elderly People Act BE 2546 (2003).

In this connection, the Health Network of People with Disabilities wishes to submit its recommendations to the 2005 National Health Assembly to provide facilities for people with disabilities and the elderly in the public area as follows:

1. A policy shall be formulated providing facilities for people with disabilities and the elderly in all new government office buildings and new public buildings belonging to the private sector, together with signs indicating the availability of such facilities.

2. Attempts should be made to ensure that the existing buildings that provide public service are equipped with facilities for people with disabilities as specified by law (Ministerial

Regulation No. 4 pursuant to the Act on Rehabilitation of People with Disabilities BE 2534 (1991)).

3. Government agencies and Local Administrative Organizations shall be authorized to use the annual left-over budget to provide facilities for people with disabilities and the elderly in their respective areas as top priority.

4. A support system should be organized to provide facilities for people with disabilities and the elderly to get better access to various services as prescribed by law.

5. Sign interpretation service should be made available, with at least one sign interpreter in every province, for hearing-impaired individuals who may need the service on a regular basis as well as in emergency cases.

6. Within the Provincial Subcommittee for Improvement of Quality of Life there shall be a working group responsible for providing facilities for people with disabilities. Representatives of people with disabilities should serve as members of the working group to help recommend and supervise activities concerning provision of facilities for people with disabilities and the elderly.

In addition, when planning on the provision on facilities for people with disabilities and the elderly in public areas is undertaken whether by the public or private sector, the representatives of people with disabilities should be involved.

Health Network of People with Disabilities
8 July 2005

8. Environmental Public Policy for Wellbeing

Area-based health assemblies had been held in six provinces, while issue-based health assemblies of environmental public policy for wellbeing 2005 had been organized in seven sub-regions, i.e. lower northern, upper northern, I-san (northeastern), central, eastern, western and southern regions, together with a forum synthesizing policy and strategy recommendations. The findings were summarized as follows:

For more than 40 years a series of the national economic and social development plans has rendered Thailand more competitive for economic growth while considerable natural resources, constituting an important factor for livelihood, have been monopolized and channeled into the industrial sector. As a result, the majority of the population could not get access to those resources which in many cases have become insufficient to sustain livelihood.

As a result of the development efforts that focused only on the economic dimension, the equilibrium was lost, affecting the ecosystem as a whole. The environmental situation has degenerated further and further. Today, Thai people in many areas have suffered in body and mind. They have to face problems on several fronts. Such problems include energy crisis, shortage of land to work on, fight for water use between the agricultural and industrial sectors, adverse effects of mining, government sector's refusal to acknowledge the resource management by the community and local wisdom, illnesses and deaths resulting from industrial

"For the community to enjoy wellbeing, the State must be in earnest in acknowledging the community's lifestyle and way of looking after its resources, water, forests and minerals, and the government must put a stop to its greed and learn the true meaning of the word sufficiency."

pollutions, as well as threats, harassments and loss of life facing those who try to protect natural resources and the environment.


At the health assembly on the specific issue of “Wellbeing” on 8 July 2005, the health assembly partnership network proposed the following recommendations designed to put an end to suffering and to create a society of wellbeing:

- The Government should quickly solve the conflicts that arise as a result of people living and working on land that encroaches on the forest reserve, to acknowledge forest management by the original community and culturally-based forest management by ethnic tribes.

- The Government should cancel the policy promoting the cultivation of single crops, especially rubber, oil palm and orange plantations and to introduce strategies for alternative farming and healthy towns as a driving force for social wellbeing.

- The Government should review the benefits from ore use, a wasteful and unworthy use of resource in view of the effects that ensue, especially in the Potash Mining Project in Udon Thani Province, and salt mining in the I-san region. In view of their far-reaching effects these projects should be halted.

- The Government should conduct water management involving the participation of the stakeholders and to acknowledge water management by the community and local wisdom. For the sewage network project that involves huge investments and for which the local community will have



to bear the costs in future, information must be disclosed to the community members regarding the costs and burden that they are expected to bear before its implementation.

- Government Agencies and Local Administrative Organizations should use mechanisms of participation and local wisdom in the management of the environment on the basis of social wellbeing. Such an example is to be found in the management of the Petchaburi basin. The project is based on the participation of all the parties concerned and on social wellbeing. With regard to forest management community participation should be conducted within the legal framework, i.e. the Act of Community Forests and the Rights of the Community, especially, the ethnic-based forest management.

- Government Agencies and Local Administrative Organizations must abrogate regulations that discriminate against forest management by the community, e.g. those that do not acknowledge the practice of crop rotation by ethnic tribes.

- Before the announcement of new natural parks is made, land for living and livelihood must be demarcated to avoid the problem of natural park land encroachment.

- The community should cooperate with the agencies concerned when it comes to protection and proper and balanced use of natural resources under the regulations that do not infringe on human rights.

9. Public Policy and Measures Aimed to Make People Drink Less Alcohol, Keep Away from It and Stop Drinking It Altogether

- Common goals should be set between the parties concerned to advocate the policy and measures to control alcohol consumption

- Clear targets for each stage of operation should be set as follows:

- **Stage 1:** to reduce social damages caused by alcohol consumption

- **Stage 2:** to reduce alcohol consumption in society.

- The Government should take action in accordance with the “Bright Economy – Safe Society” policy announced by the government and in line with various statements made by the national leaders to the public, e.g. statements explicitly made by the Prime Ministers and Deputy Prime Ministers on protection of young people and society from adverse effects of consumption of alcoholic drinks.

- The National Alcohol Consumption Control Committee (NACCC) should:

- **Review measures aimed to limit advertisement of alcoholic drinks** - Many alcoholic drink manufacturers have re-adjusted their advertisement and sales promotion strategies after finding the loopholes that come with the attempt to confine advertisement to only some media. As a result, they have vigorously resorted to other forms of advertisement and sales promotion. The Committee, therefore, should review the measure to ban all forms of advertisement of alcoholic beverages.

"All public policies will bear fruit
only if we start with ourselves by
vowing to *refrain from drinking*
during the Buddhist Lent."

- **Review measures to limit the points of sale** - Only a certain number of shops should be allowed to sale alcoholic drinks. No sale is permitted in some areas, e.g. those close to monasteries and schools.

- **Consider legislating** - to control the consumption of alcoholic drinks in an integrated and comprehensive manner to ensure effective implementation.

- **Focus on the strategy of creating or raising awareness in teenagers** - as to the impacts and losses that may arise as a result of alcohol consumption.

- **Designate specific government authorities as lead agencies on the ground** - e.g. provincial governors, police stations and provincial public health offices.

- Thai Health Promotion Foundation (ThaiHealth) should promote the creation of networks at the community level, especially those that conduct activities or set measures to control alcohol consumption in the community. For instance, support should be given to the civil sector to prepare reports on the country's situation of alcoholic consumption, to the monks' measures not to perform religious ceremonies at parties, funerals or cremations where alcoholic beverages are served, and to the measure disqualifying alcoholic members of the community from borrowing money from the community fund.

- When an alcoholic drink business is listed in the stock market to mobilize capitals, its business will be even further strengthened. There is a risk that the market could be easily interfered by its business power because the mechanism to

ensure a political balance of power is not yet strong enough at the moment. The following policy recommendations and measures are made, therefore, to the Stock Exchange of Thailand regarding the alcohol business:

- **Process governing the listing application** - The Securities and Exchange Commission (SEC) should consider overall impacts if the business is listed.

- **Measure supervising the listed business** - Measures must be put in place to ensure good governance and a proper code of conduct, e.g. no advertisement targeting children and youth, no sex-related advertisement, no encouragement of heavy drinking, and strict compliance to the law.

- The target groups for treatment should cover those who are at risk as well as the alcoholics. Cooperation should be sought from the Provincial Public Health Office to act as a coordinating body at provincial level to ensure work progress and effective implementation.

- There should be "lead" or main agencies to take care of problems of drunk driving, committing crime or violence while under the influence, and treatment, each with a clear line of responsibility and a proactive approach to the issue for better coordination.

- Various local government agencies concerned should be involved in providing recommendations and support of value creation and strict law enforcement at provincial level.

- The community should be strengthened in integrating activities designed to make people drink less alcohol into the

community learning and development process.

- A social network should be established in order to create the environment conducive to making people drink less alcohol, keep away from it and stop drinking it altogether.

- Measures for the government sector to enforce the existing laws and expedite legislature:

- ***For laws limiting the age of the buyers*** - The present Child Protection Act of B.E. 2546 (2003) should be seriously enforced. Mechanisms and personnel concerned should also be developed and strengthened since this law is still new to Thai society.

- ***For laws designed to prevent “drunk driving”*** - Attempts should be made to encourage police officers to strictly enforce the laws as much as possible. The officers should be equipped with enough supplies of breathalyzers and blood alcohol content measuring machines and knowledgeable about using them effectively. More activities should be undertaken to measure blood alcohol levels in drivers/riders especially in the areas near entertainment establishments and should not be confined to late night hours but to cover the evening from 20.00 to 22.00 hours as well.

- ***Measures to control production and sale of alcohol:***
 - Higher pricing of alcohol should be controlled through taxation and duty levies, recommending an increase in price for all types of alcoholic drinks while care must be taken not to drive the drinkers to other cheaper or illegal alcohol beverages instead.

- The packaging size should be controlled,

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making sure that it is inconvenient to buy and that warning labels are not shown in the form of statement but in the form of dangers to health, including information on penalty on the drinker who violates traffic regulations or other laws concerned.

- Products should be controlled, especially those enticing children, young people and women to try alcoholic drinks as a novelty or popular lifestyle.

- Zoning should be imposed, limiting the areas for sale or consumption of alcoholic drinks, e.g. forbidding the sale of alcohol in the areas near schools or monasteries, forbidding sale and consumption on the premises of government offices, and setting a residential zoning to be free from entertainment establishments as opposed to an entertainment establishment zoning.

- The fees for licenses to sell alcohol should be increased and requirement for such licenses should be set tough with a view to reducing the number of places that sell alcohol.

- ***Measures to control consumption:***

- The age limit for buying alcoholic drinks should be raised from 18 years, the minimum age prescribed by the Child Protection Act B.E. 2546 (2003), to a higher age so as to reduce the number of new drinkers.

- The places for drinking alcohol should be limited. It is recommended that ban on drinking alcohol be imposed in more and more places, e.g. schools, monasteries, hospitals and government offices, vehicles in which the drinking

ban applies to the driver and passengers alike, parties held by government agencies.

- Measures to control alcohol advertisement:

Control must be put over marketing communications of all types, in all forms and through all channels. Advertisement includes publicity, sale promotion, activities organized in shops and at points of sale and other forms that a particular brand may want to adopt. The measures to be used are as follows:

- Total banning of marketing and brand communication will be imposed.

- Advertisement is allowed under conditions of the least possible impact on society and adheres to the "burden maker bears the burden" principle. The manufacturers and sellers must pay for the time and space that the Thai Health Promotion Foundation (ThaiHealth) uses to publicize the campaign for alcoholic consumption control at the same rate that they do to advertise their own products. Higher advertisement taxation can also be levied on the alcoholic drinks to push their prices even higher. This is an urgent measure as it will have an important impact on the drinking situation.

- Measures to mitigate the consumption impact:

Penalty on "drunk driving" should be reviewed and made stiffer with the following measures:

- Emphasis should be put on imprisonment for two days with no bail allowed.

- Another penalty should be imposed on the "drunken drivers" who will have all the driving licenses revoked.

- The blood alcohol content level of teenage drivers/riders should be readjusted to zero, because at their age they are easily stimulated both physically and psychologically and can be carried away with excitement and with little self-restraint.

- A stiffer fine should be imposed on the driver/rider whose alcohol level is higher than the law prescribes.

- Social measures should be implemented to encourage individuals and organizations develop a moral code of conduct as follows:

- **Public figures** such as TV/film stars, singers or celebrities should refrain from being presenters for advertisement of alcohol companies.

- **Government and government-related agencies** should refrain from accepting sponsorships from alcoholic drink companies when organizing events or other activities. Civil servants or government officials should not get involved in activities designed for all kinds of alcohol sale promotion, including social activities aimed to promote sale or project a positive image of the alcoholic drink companies.

- **Local Administrative Organizations** should not spend their budgets buying alcoholic beverages or organize activities that involve alcoholic drinks.

- **At education institutes**, university activities organized by teachers and students should have nothing to do with alcohol; nor should they accept sponsorships from alcoholic drink companies. Besides, faculty members who

are found guilty of alcohol-related acts should be severely punished.

- **Workplaces** should have a policy not recruiting new workers who are alcohol drinkers and use no alcohol consumption as a criterion for evaluating the workforce performance.

10. Media and Fostering Wellbeing

- The Government should stop interfering, buying off and dominating the media.

- The Government should improve the Department of Public Relations and allow the people wide access to the power of the media.

- The Government should select and appoint the new National Communications Commission (NCC).

- The Government should promote media diversity.

- The Civil Sector should advocate the creation of an independent and ethical institution/mechanism/central agency that plays an important part in rating the quality of the media and sending warning signals to the consumers.

- The Civil Sector should promote standard/reliable media.

- Education institutes should produce quality mass media professionals.

- The Civil Sector should advocate policies that promote multiplicity and diversity of mechanisms designed for health communication.

- The Civil Sector should promote alternative media

"The civil sector, media receivers, media and State shall take into account the following factors:

- The right to be informed of the news and facts from all sides and from diverse media.

- Advocacy for policies or an independent mechanism/central agency that plays an important part in rating the quality of the media, auditing the media and sending warning signals to the media receivers.

- Support should be given to resource and expansion of alternative media or the people's sector media.

- The media receivers must develop self-immunity, be well-informed, criticize and audit the media.

- The State must stop interfering and dominating the media, while ensuring a fair distribution of power in the new media administration."

as well as the people sector's media.

- The Civil Sector should promote reading more widely.
- The Civil Sector should prepare the media master plan that the people need.
- Media receivers and Consumers should develop self-immunity so as to be able to voice own ideas and criticize the media.
- Media receivers and Consumers should express opinions to media producers, agencies or administrators on a regular basis.
- Media receivers and Consumers should boycott bad media or latent advertisement.
- Media receivers and Consumers should support alternative and cultural media.
- The Media should develop the system capable of auditing media ethics.
- The Media should open space for the civil sector or the owners of issues.
- The Media should promote organizational development for self-regulating purposes

11. Healthy Thailand Strategy for Wellbeing

- The Government has declared the ***“Healthy Thais, Healthy Thailand”*** policy as a national agenda capable of leading to the state of wellbeing for Thai people. To materialize this goal, every sector in the country needs to be seriously involved. This will be made possible by the Government's serious and constant efforts to move the agenda forward.

"Healthy Thailand is a country where people enjoy wellbeing, physical, mental and spiritual, where the communities help each other and where people's livelihoods are based on sufficiency economy. For this dream to come true, one needs good and appropriate strategies and good systems represented by the State policy at the macro level and by the self-reliant community at the micro level."

- In the government sector, every ministry should set its strategies and goals in support of the national agenda of ***Healthy Thais, Healthy Thailand***, focusing on the coordination of the networks vertically as well as horizontally. Success indicators should be based on community participation and may differ from community to community, with attention given to the development process.

- In addition to the participation from all sectors, support must be given to administrative efforts to ensure effective implementation of the project strategies at all levels.

- Local Administrative Organizations should play a crucial role in supporting the development of the wellbeing of the people under their jurisdiction under the national agenda of ***Healthy Thais, Healthy Thailand***.

- Effective support could entail the development of the potentials of the local administrative organizations in the areas of personnel and organization development. For instance, a development management system must be put in place to make it easier for people and all sectors concerned to participate. There must be local development plans focusing on the development of the quality of life or wellbeing of the people. Support must be given to community plans and an effective administrative practice.

- Political and natural community leaders, such as group leaders and various groupings, should play an important part in strengthening the community and bringing about real and sustainable wellbeing of the community. They can coordinate

with the group networks to prepare a development plan for community wellbeing that is in line with both the community context and the strategy of **Healthy Thais, Healthy Thailand**. Such action will involve the participation of community members, young people and the support of various alliances and networks to ensure that it meets the needs of the community.

- A family is the smallest but most significant unit that can bring about the wellbeing of its members. It is only natural, therefore, that every family should be encouraged to develop its wellbeing process.

- All organizations whose work is designed to support community development should join hands working together as a network of alliances with the community. With the community as the development focus, their common objective is the wellbeing of the people. They work in concert with the strategies and goals of the national agenda of **Healthy Thais, Healthy Thailand**, while paying special attention to social development through the family, religion and education as well as all the lessons learned, success stories and mistakes from past experience.

- Mass media should play a very important role in educating society and in generating social interests. To support the participation of all sectors in the country in order to bring about wellbeing in line with the strategy **Healthy Thais, Healthy Thailand**, media of all types should be more active in supporting the national agenda of **Healthy Thais, Healthy Thailand**.

12. Local Traditional Wisdom and Local Traditional Healthcare for Wellbeing

Over the years the mainstream or Western medicine has responded well to the development directions of the country and enjoyed considerable support from the government sector. As a result, other medical systems, especially local traditional medicine, including Thai traditional medicine, have been pushed out of the community. People have to depend more and more on Western medicine. At the same time, local traditional doctors, who are left stranded in the community, have come so much under the influence of capitalism that they too have attached less importance to traditional values and relationships which form an important and fundamental part of the strength of the community. Therefore, the following recommendations are made:

- The Ministry of Public Health should develop and provide people with more opportunity to seek healthcare alternatives by promoting and developing other medical systems.

- There should be strict legal measures and action against those who falsely claim to have knowledge of medical treatment based on local or Thai traditional medicine. This will help reduce the obstacles to the development of Thai and local traditional medicines.

- Attempts should be made to change the way of thinking of government officials about appreciating other medical systems.

"Local wisdom is worth more
than treasure, As it is part of
a happy local traditional life,
Enabling life to go on
without suffering.

We together should help
preserve it.

Looking back over the years
we now realize People have
taken the wrong path, sad to say;
Having forgotten local wisdom,
the community is now
floundering.

We should all help preserve it
for the sake of our wellbeing."

- The Government should develop and promote other elements concerning the development and promotion of local and Thai traditional medicines, such as community rights, economy and law.

- Training should be organized to enhance the competency of local traditional doctors who are also spiritual healers.

- The Food and Drug Administration (FDA) should modify its role from exercising strict control and supervision to supporting the development of Thai traditional medicine and herb.

- Thai and local traditional medicines should be developed alongside the Western counterpart.

- The Food and Drug Administration should allow communities and community members to produce and sell herbal products (there should be no discrimination against them).

- The State must provide funding to support and promote local traditional medicine and people involved with such medicine.

- Efforts must be made to apply His Majesty the King's principle of Sufficiency Economy.

- The I-san region proposed that there a council should be set up to promote community health and that the Local Administrative Organizations should provide budget to support it.

- The community members must come together as a united force and should not bicker with each other over trivial

matters of self-interest. This will lead to a stronger community and more reliance on local traditional medicine.

- The community should revive and study local traditional medicine by themselves or with academics and doctors who understand such medicine.

- The community should select, support and promote people who can take on local traditional medicine.

- The community should organize its body of knowledge and activities to promote learning within the community, as well as setting up its own fund.

- Herbal cultivation should be promoted and used to support the family's income and economy.

- The profit-oriented business sector has taken over the community healthcare sector, thus making it difficult for community members to get access to Thai and local traditional medicines and other health products and obstructing the attempt to establish self-reliant entrepreneurship at the community level.

- Schools should improve their curriculums and educate young people about local traditional medicine, including traditional massage. Attempts should be made to change the students' attitude about the value of massage that it is not a business, and they should be given more instruction on local traditional medicine.

- In cases where diseases and illnesses have become very serious and spread across the national border, organizations should join hands to restore the inter-dependent relationship system or to create the relationship system that transcends

the village and community border. Such an act will provide immunity to those illnesses.

- The research community should ask new research questions that reflect the changing situation. For instance, research is undertaken to assess the consequences when legal measures are introduced to interfere with the work of local traditional doctors or if there are attempts to develop new curriculums or produce new types of local traditional doctors.

- There should be more research on local traditional medicine regarding its efficacy and systematic proofs of such treatment together with rational explanation.

- Research should be conducted to support the strength of local traditional medicine and eventually to develop textbooks on the subject.

- The mass media should help advocate Eastern medicine to redirect the thinking paradigm of society.

- The media should present positive as well as negative aspects of local traditional medicine. They should refrain from presenting the negative image or adverse effects on the health of those who use local traditional products.

- **Declaration of Intent on “Working Together to Build a Society of Wellbeing”**

A declaration on “Working Together to Build a Society of Wellbeing” formed the basis of our mission and commitment to creating a society of wellbeing through working together, promoting, monitoring, moving and advocating all relevant health issues.

Declaration of Intent

Working Together to Build a Society of Wellbeing

Desiring to see Thailand a society of wellbeing in which all Thai people enjoy good health, the members of the 2005 National Health Assembly unanimously agree to declare the following nine principles to mark the starting point of the movement toward a society of wellbeing:

1. We, Thai nationals, being united, friendly, and helpful to one another, will work together with mutual respect and without distinction of race, religion, ethnicity, or social status in our effort for wellbeing.

2. We will work together to promote self-sufficiency and follow the principle of sufficiency economy as graciously advocated by His Majesty the King at the family, organization, community and national levels.

3. We will work together to promote valuable Thai culture and traditions, revive valuable traditional social values and wisdom, and enhance the role of religion and morality in our lives for wellbeing.

4. We will work together to promote and put in place physical, biological and social environments conducive to wellbeing, to increase public space for community activities and learning, and to encourage extensive and diverse voluntary work for social good.

5. We will promote and work together to organize learning at every level, using various tools and methods, for instance, keeping household income and expense accounts, preparing community master plans, and organizing forums where

people come together to solve problems and to exchange learning in a participative manner.

6. We will promote and support a friendly process that facilitates working together and mutual learning between the civil sector, local administrative organizations, government sector, private sector and other sectors in the society. Activities include formation of knowledge-management groups, maximizing of potentials and transfer of learning and experience, organization of public forums to exchange knowledge, monitor, audit, and advocate wellbeing, communications, and mobilization for resource support purposes.

7. We will work together to make sure that there is a public policy geared toward creating self-sufficiency and a balanced lifestyle for wellbeing, reducing, curtailing and preventing an unhealthy and unhappy lifestyle, as well as various factors that give rise to such lifestyle, at the local and national levels.

8. We will develop wellbeing indicators at the family, organization and community levels and work together to develop indicators of national wellbeing, using the process of indicator development as an instrument to develop wellbeing at the same time.

9. We maintain that it is the duty of all parties in the society to constantly work together to promote, support, monitor, advocate and bring about a society of wellbeing, while the government sector will seriously undertake to promote and support the programme on a continual basis.

**Announced on 8 July 2005
2005 National Health Assembly**

“The Fifth National Health Assembly had done its duty to advocate a democratic participatory process. The Policy and Strategy Recommendations collected were the result of the screening of several bodies of knowledge and elucidation of analytical thinking from many sectors and at many levels of the assembly process. They constituted a way to help create wellbeing in society and eventually to a society of wellbeing.

These policy and strategy recommendations, therefore, were the fruit of well thought-out and analytical pursuit characteristic of the health assembly process. To turn them into a public policy and practice that would move society forward would require strength and cooperation from many sectors at many levels. To monitor, advocate and multiply the work were all part of the “Triangle Moves the Mountain” strategy, i.e. we needed to create a body of knowledge (the academic sector), encourage social movement (the people sector) and coordinate with the political and government sectors. Needless to say, without full support and cooperation, or with the weakening of any sector, we would never reach the destination. Or if we ever got there at all, it would take much longer than it should.

The Policy and Strategy Recommendations were considered as a joint commitment for everyone and every sector of the society to embrace. It was an attempt to move together concertedly to bring about true wellbeing in society and realize a society of wellbeing for everyone and every sector of the society to enjoy.

4.

Crystallization of Learning:
For Future Health Assembly



CHAPTER 4

Crystallization of Learning: For Future Health Assembly

Over the five years HSRO's role had been to coordinate the organization of the health assemblies, providing conceptual input and budgetary support. It had completed its mission in drafting the National Health Act, it would have come to an end sooner or later. All the efforts by HSRO to set up and nurture the health assembly had operated under a set of assumptions in the constantly changing environment. Several academic teams had joined force with HSRO. The five years of the health assembly development had seen mixed results. Some outcomes were highly commendable, while others needed improvement.

The crystallization of learning from the process would help us look toward the future of the health assembly, including its suitability and its contribution to other social development processes.


"The participatory learning process, therefore, was an important factor in strengthening the health assembly... real success was the presence of the learning process whereby people in society could exchange knowledge, leading to a change in the value system, health behaviours and collective efforts to create a society of wellbeing."

• Health Assembly and Creation of Social Learning Process

The strategic aim of the national health system reform was not simply to pass the National Health Act but to use the legislative process to engage the three sectors - people, academic/professional, and government/political – in the discussion about health reform. It was meant to be a learning process designed to bring about a new concept about health on which to build a future health system.

The participatory learning process, therefore, was an important factor in strengthening the health assembly. Uthai Dulyakasem *et al* (2004), who evaluated the health reform process, viewed that the Thai society had already witnessed the role of civic groups in health-related issues in some way even before HSRO came into the picture. HSRO helped them to sustain their work more effectively and improved the learning experience for public purposes. The office encouraged the organization of forums and learning activities in innumerable areas. Some issues were taken from the local to national levels as part of the public policy process. Others that were not taken up were used as exercises in the development of the learning process about public policy in the locality. Such an outlook reflected the basic philosophy of the health assembly that real success was the presence of the learning process whereby people in society could exchange knowledge, leading to a change in the value system, health behaviours and collective efforts to create a society of wellbeing.

Nevertheless, the knowledge generation work of



HSRO was not always completely successful. Some localities still lacked depth in their approaches. Several forums were only activities to stimulate the learning process rather than to obtain any meaningful learning outcome. The leaders of the groups/networks were far from understating the concept and principles of health promotion vis-à-vis treatment; they tended to be stuck in their own agenda. In this regard, there was still room for improvement.

On HSRO's efforts to create more than 1,000 learning groups/networks, the research team commented that the achievement level often depended on the existing capitals or background of the locality or province concerned. Those with a strong civil society presence, including the community's health networks and people sector's health groups, would find it easier to develop their activities, especially in "banding" their networks. The areas where improvement was needed were bridging partnerships, linking learning experiences, creating trust, and showing concrete commitment toward the goal of the National Health Assembly.

An important point was that once the civic groups came together to advocate health issues they were able to organize a health assembly (or any other name) by themselves without HSRO's help. Consideration should be given to how to create in these groups a sense of ownership of the health issues, how to bridge them together, and how to make them grow even further.

These evaluations revealed that on the whole there was still a lot to be done to improve the learning process about


health at national level, while success at the local level was clearer, albeit only in some localities. Dr. Kanittha Nanthabutr and team studied the sub-regional health assembly processes in the provinces of Khon Kaen, Maha Sarakham, and Udon Thani and had this to say. ***The provincial health assemblies held in July 2004 reflected four important roles: 1. generating thoughts, 2. crating a participatory process, 3. creating a learning culture, and 4. creating and developing leadership. Such roles indicated that the health assembly should facilitate the learning process and provide a good example which the locality could adopt while taking into account other relevant factors.***

This view corresponded with the findings of Dr. Seri Phongphit who synthesized happiness-promoting innovations from 20 communities (HSRO, 2005, revised in 2008). The researcher mentioned that the health assembly movement for health reform effected qualitative changes at the grassroots in several localities. To some extent the local issues were linked to the spirit of the draft National Health Act. In addition, the evaluation reports from several academic teams all reflected that the health assembly has led to “many good things” about the learning process. The health assembly was a successful creation, although its quality and sustainability would need further proof.

- **Health Assembly and Political Reform of the Civic Sector**

Dr. Komatra Chuengsatiansup and team analyzed the health assembly process in 2003 in terms of the civic sector

"This was an open and dynamic interaction between the government and civil society sectors. There was no clear-cut them and us. Rather, it was a window of opportunity for seeking cooperation or striking a balance of power depending on the context."




movement. The research team indicated that as part of the national health system reform the health assembly had a number of distinguished duties and roles:

1. It served as a forum to make an argument against something on a rational basis. This function was missing in the traditional public administration sphere where the State exercised its unchallenged legitimacy in making decisions on behalf of the people. The people's role was simply to cooperate and comply with the State policy on the principle of "implementation without deliberation". The health assembly, therefore, served a "deliberative function of governance", providing an opportunity to re-consider the State policy characterized by top-down policy-making and no public participation. It was a process aiming at a health system reform and inviting the people from all sectors to discuss and seek solutions together on a rational, participatory and consensual basis.

2. The health assembly reflected a horizontal egalitarian relationship. The format of activities was informal and friendly with no hard and fast rules. The participants need not be well-dressed, nor were they required to sit in a formal or orderly setting. Cultural expressions were used to reaffirm political and local identities that were diverse and mutually acceptable.

3. If the health system reform was considered a form of social movement, the National Health Assembly held during 7-8 August 2003 clearly reflected a political dynamism of the civic sector. There was much negotiation,



auditing, opposition, and coordinated cooperation between the civic and government sectors without pre-determined rules. We also saw how some of the government structure and mechanisms could be used to promote and support the community sector, while some health communities might have their own agendas contrary to the government policy and directives. Thus, this was an open and dynamic interaction between the government and civil society sectors. There was no clear-cut “them and us”. Rather, it was a window of opportunity for seeking cooperation or striking a balance of power depending on the context. This was one of the most outstanding characteristics of the health assembly. Such open relationship made it possible to find new grounds whether through challenges or cooperative efforts.

In general the research team viewed the health assembly as reflecting a salient feature of the Thai health system different from the models in other countries. In particular, the citizen concept was used as an integral part of the civil society movement drawing strength from various community groups/networks and not relying on the government initiatives. It was a story of growth and democratization of the civil society sector.

To put the Thai health system reform in the international perspective, the author wished to refer to the First People's Health Assembly (PHA). PHA was mostly driven by the people sector, while the Thai health assembly focused on the linkage between the academic and political sectors. Although the Thai approach had not yet won over the political counterpart, it was

clear that it would be driven by knowledge and reconciliation moving from the local to national levels. The First People's Health Assembly, on the other hand, witnessed an apparently adversarial expression against the authorities. For example, several assembly members sat in protest during a presentation by one of the World Bank's representatives. Regarding the physical, spiritual, social and intellectual dimensions of health, the Thai and world assembly approaches were in tandem. They shared the same outlook toward the impact of public policy on health although the focus of PHA was more global, e.g. free trade policy put forward by the World Trade Organization (WTO), policy of the World Health Organization (WHO) and United Nations (UN).

- **Health Assembly and Its Role in the Public Sphere and Techniques for Public Participation through the “Triangle that Moves the Mountain” Strategy**

The health assembly adopted the “Triangle that Moves the Mountain” theory as its philosophy, giving itself a unique identity different from health movements in other countries. The Thai slogan “Wisdom and Reconciliation” captured the essence of the Thai health assembly succinctly.

The “Triangle that Moves the Mountain” philosophy was used as a basis for determining the health assembly membership in the draft National Health Act, with 60% from the people sector and the rest coming from the academic/professional and government/political sectors. Over the past five years, the civil society sector had shown considerable

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enthusiasm, while the other two sectors showed little interest, resulting in an unbalanced participation. In a sense, the situation proved, at least in the Thai context, that the triangle would not move forward if one or more of the pillars were missing.

Uthai Dulyakasem *et al* (2004) commented that the reason why the “Triangle that Moves the Mountain” strategy did not produce the desired result was that the government/political sector had become more powerful and did not attach importance to the education of social movements. In this regard, the strategy was weakened. Nevertheless, the strategy that the Thai health system reform successfully adopted was to mobilize the academic/professional sector, the government/political sector, and the people sector in the drafting of the National Health Act. The results that were achieved could be considered valuable **“social capitals”**. The question remained: while we were waiting for the passage of the National Health Act, how could we make proper use of these “social capitals” to render the principles of the act into concrete action?

- **Health Assembly and Participatory Healthy Public Policy Process**

After two years of the National Health Assembly, HSRO and its partners learnt more about the role, function and meaning of the health assembly. The first and second years were devoted to dissemination and advocacy of the draft National Health Act, while the third year onward was intended to bring about concrete results of the health

assembly. This was made possible by having discovered issues facing various localities. The task at hand was to develop policy and strategy recommendations, have them implemented through various mechanisms, and crystallize the experience into knowledge to advance the cause further. The health assembly would come to be known as a participatory public policy process, leading to a set of clear objectives and direction, together with policy and strategy recommendations supported by substantive and weighty evidence.

However, it was recommended that in order for policy recommendations to move society forward, HSRO and the assembly organizers need to promote an attitude in the government sector to implement the health assembly and public policy process initiated by the people sector. The recommendations, however, must be fully based on information, academic evidence, sound principles and rationale. They must also be practical and clearly beneficial to the public. It was an important to adopt such an approach, because the government sector's philosophy was primarily to serve the public. If the health assembly's recommendations corresponded with the people's needs, its success would be assured.

- **Recommendations for Future Health Assembly**

The study on "Birth and Development of the Health Assembly: Experience and Lessons Learnt of National Health System Reform Office (HSRO)" by Dr. Uthai Dulyakasem, Dr. Naowarat Plainoi, and Dr. Wirat Kamsrichan made the

following recommendations on the next phase of the health assembly:

1. More efforts should be made to continuously develop quality learning on health as a basis for new thinking and greater awareness, drawing strengths from the non-health sector, while the message of learning should primarily be more oriented to health and the public.

2. The health groups/networks should be better empowered to prevent any structural problems that might arise when the Health Act was finally passed. This would ensure that the people sector would be strong enough to present its health agenda. From the lessons learnt over the years, the government and political sectors were not opposed to the concept and principles of civil society groups but had problems with their operational mechanisms, as had been the case with the 1999 National Education Act.

3. Compared with the local health assemblies, HSRO attached greater importance to the national forum. In future, more focus should be given to local advocacy, for example, at the levels of Tambon Administrative Organization, Provincial Administrative Organization, and Municipal. This would ensure a strong and secure foundation. The learning forum at the local level should be given more attention to ensure a quality delivery with support from the academic network. It should be designed in such a way that all parties concerned would have a greater sense of ownership of the process. The local assembly leaders should select strong potential members to attend the central forum so that they could make meaningful

contributions to the cause.

4. Efforts should be made to bring about reform synergy. As a result of the power excessively held by the government/political sector, little importance was given to the promotion of learning and social movement. Therefore, new ways must be developed on how to manage the “Triangle that Moves the Mountain” concept. At the same time, the civil society groups need to work and think beyond their own self-interests. The next phase should see more synergy of efforts from all sectors and groups with a shared vision.

5. There should be an agency to carry the HSRO mission forward. As HSRO’s role would sooner or later come an end and if the draft National Health Act was not passed, there should still be a central agency with a number of qualified people to continue and coordinate the health reform work with potential local groups. This agency need not be equipped with many resources but should rely on the resources of local administrative organizations with the common ideal and interest.

6. There should be knowledge-generating efforts and capacity building in preparation for change and health system reform especially in the continually changing context. (For example, knowledge synthesis should be made in the locality to gauge how far and by what methods the local groups/networks have progressed.) There should also be research on social capitals that have accrued in the locality as a result of health movement.

All in all, the mechanism to carry HSRO's responsibility forward must be clear about what to do and take into account appropriate strategies; otherwise, all the hard work and worthy efforts during the past years by HSRO would be sadly lost.

"Is the quality of audience participation a matter of individual excellence? How could we turn this into a collective force?"

Srisawang Puawongpaet

"Those in power may not understand its profound philosophy and concept, so they may be afraid that they will lose some of their power. The problem may come from the way information is provided."

Prawase Wasi

National Health Act Drafting Sub-committee Member

"The process that will engage more coverage needs good management. The flowers in the field will soon be in full bloom. How could we make them grow even further? Should we let them wither and die?"

Pichai Srisai

Civil Society, Songkhla Province

"The health assembly is a social process. If it could bring about a management system and learning process at the local level, it will be even better. This will be possible if it has a self-sustaining mechanism."

Mr. Paiboon Wattanasiritham

Chairman, Organizing Committee of 2001-2004 National Health Assembly

"Over the past years the health assembly has been evolving, with HSRO acting in a virtual organization. More efforts are needed to make the assembly go faster and stronger in this transitional period. Today, it will need a real organization to carry the cause forward."

*Somkiat Poothamsiri
Civil Society, Sa Kaeo Province*

"The health assembly process relies on a discourse on happiness or health promotion. It is not designed to scrutinize the government sector. So, its discourse and concept play a very important part here. For example, the approach to the healthy public policy is praiseworthy in its attempt to bring knowledge management to the community."

*Dr. Nirun Phitakwatchara
Member of the Senate, Ubon Ratchathani Province*

"Reform of this type will not produce quick results and or prove beneficial in a short run. It is a measure that gives long-term results. It will take at least five or ten years before one can see a change in health behaviour and more participation from the people sector...This is a new way to work. One has to learn how to do things by oneself."

*Komatra Chuengsatiansup
Social and Health Research Institute*

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EPILOGUE

The current of the health system reform has flown uninterrupted for more than two decades, creating wave after wave, some big, others small. As a whole, the health current has followed the same objective and direction toward “health” in all its dimensions – physical, mental, social and spiritual – through diverse processes. What these processes have in common is the willingness to accept, explore and promote the role of the people sector in the development of the national health policy through learning and working with the political sector.

The health assembly is a series of learning waves that are happening everywhere all at once. The five years of experience have seen thousands of health forums organized by health partners covering many issues and exchanging their learning, all geared toward a better understanding and undertaking of the health assembly process. The experience will help to set some kind of standard for the future health assembly. At the same time, it can be applied to cases other than health. The learning is always two ways.

The flow and share of experience and wisdom of the networks in the health reform system movement have led to a greater awareness to develop “wellbeing for Thai people”. Yet, in the present social system, there are many contrary forces that are giving rise to unhealthy lifestyles. It is our duty, therefore, to continue our advocacy for good health and wellbeing.

